2019 Molina Healthcare of Washington, Inc. Agreement and Individual Policy

Molina Choice Silver 200

Washington

21540 30th Dr. SE, Suite 400, Bothell, WA 98021

You have 10 days to examine this Agreement. Return it to Us if You are not satisfied for any reason. We will refund premiums paid to You upon return of the Agreement and the Agreement will be considered void from the beginning. If any Covered Services have been rendered or claims paid by Molina Healthcare during the 10 days, You will be responsible for repaying Molina Healthcare for the services or claims.

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKA NATIVE THAT HAS A COST SHARING REQUIREMENT IN YOUR PLAN THEN YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PLAN FOR ANY COVERED SERVICES NOT PROVIDED BY A TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.

MolinaMarketplace.com

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. If you need help, call (800) 368-1019; TTY (800) 537-7697.

MOLINA HEALTHCARE

Your Extended Family.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-295-7651 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-295-7651 (TTY: 711).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-888-295-7651 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-295-7651 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-295-7651 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-295-7651（TTY：711）。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-295-7651 (رقم هاتف الصم والبكم: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-295-7651 (TTY: 711) 번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-295-7651 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-295-7651（TTY: 711）まで、お電話にてご連絡ください。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-295-7651 (TTY : 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-295-7651 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-295-7651 (телетайп: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-295-7651 (TTY: 711) पर कॉल करें।
Persian (Farsi)	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-888-295-7651 تماس بگیرید.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-295-7651 (TTY: 711).

MOLINA HEALTHCARE OF WASHINGTON, INC.
SCHEDULE OF BENEFITS
MOLINA CHOICE SILVER 200

THE SCHEDULE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF WASHINGTON, INC. AGREEMENT AND INDIVIDUAL POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.

NOTICE: THIS POLICY DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS COVERAGE IS AVAILABLE THROUGH THE HEALTH BENEFIT EXCHANGE. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE AGENT OR THE HEALTH BENEFIT EXCHANGE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STANDALONE DENTAL PRODUCT.

Except for Emergency Services, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum. Your provider network is Molina Marketplace.

Deductible Type	At Participating Providers, You Pay
Medical Deductible (Applies only to Emergency room, outpatient Hospital/facility and inpatient Hospital/facility services)	
Individual	$3,300
Family (2 or more Members)	$6,600
Prescription Drug Deductible (Applies to Tier 3 and Tier 4)	
Individual	$400
Family (2 or more Members)	$800
Annual Out of Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$6,300
Family (2 or more Members)	$12,600

[1]Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Your Annual Out of Pocket Maximum.

Emergency Room and Urgent Care Services	You Pay	
Emergency Room[2]	30%	Coinsurance after Deductible
Urgent Care (Participating Provider)	$50	Copayment per visit

[2] This cost does not apply if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital/Facility services, for applicable Cost Sharing to You)

Please note: You may be responsible for provider charges that exceed the Allowed Amount covered under this benefit for Emergency Services rendered by a Non-Participating Provider. Please refer to the section of the Agreement titled "Emergency Services and Urgent Care Services" for more information.

Outpatient Surgical and Non-Surgical Services[3]	At Participating Providers, You Pay	
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$20	Copayment per visit
Specialty Care	$60	Copayment per visit
Other Practitioner Care	$20	Copayment per visit
Habilitative Services (limited to 25 visits per calendar year)	$60	Copayment per visit
Rehabilitative Services • Speech, physical and occupational therapy, combined limit of 25 visits per calendar year • Spinal manipulations limited to 10 per calendar year • Acupuncture services limited to 12 per calendar year (limitation for acupuncture does not apply if done for chemical dependency)	$60	Copayment per visit
Mental Health Services (Includes mental health and behavioral health medically necessary treatments and eating disorder treatments for DSM classified disorders)	$20	Copayment per visit
Substance Use Disorder Services (Includes chemical dependency detoxification, and; unlimited Acupuncture treatment services when provided for chemical dependency. All are subject to medical necessity criteria.)	$20	Copayment per visit
Nutritional Counseling	$20	Copayment per visit
Phenylketonuria (PKU)		
Preventive Care for Children and Adults	No Charge	
Testing and Treatment of PKU	$20	Copayment per visit
Diabetes Management		
Preventive Care for Children and Adults	No Charge	
Diabetes Care other than Preventive Care	$20	Copayment per visit

Cancer Chemotherapy and Other Provider Administered Drugs. **Note:** Please refer to the Outpatient Hospital/Facility Services or the Inpatient Hospital Services sections of this document for more details.	30%	Coinsurance after Deductible

Pediatric Vision Services (for Members under Age 19 only)		
Vision Exam (Routine vision screening and comprehensive eye exam which includes dilation as professionally indicated and with refraction every calendar year.)		No Charge
Prescription Glasses		
Frames	• Limited to one pair of frames every 12 months • Limited to a selection of covered frames	No Charge
Lenses	• Limited to one pair of frames every 12 months • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, and ultraviolet protection (UV)	No Charge
Prescription Contact Lenses		
Limited to one year supply every 12 months, in lieu of prescription glasses as Medically necessary for specified medical condition		No Charge
Low Vision Optical Devices and Services (subject to limitations and Prior Authorization applies)		No Charge

Dental & Orthodontic Services		
Temporomandibular Joint Syndrome (Medically Necessary Non-surgical Treatment)	30%	Coinsurance
Family Planning (These services include all women's contraceptive drugs, devices and products approved by the Federal Food and Drug	No Charge	

[3]**Please note, if You are seen in a hospital-based clinic, outpatient hospital Cost Sharing may apply.**

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgery		
Professional	30%	Coinsurance after Deductible
Facility	30%	Coinsurance after Deductible
Reconstructive Surgery	30%	Coinsurance after Deductible
Internally implanted devices (surgically implanted hearing devices/cochlear implants, pacemakers, intraocular lenses, hip joints etc.)	30%	Coinsurance after Deductible

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Specialized Scanning Services (CT Scan, PET Scan, MRI) (Unless these services are performed while You are in an inpatient setting, Your Cost Share amount for these services will apply.)	30%	Coinsurance after Deductible
Radiation Therapy (for the treatment of cancer)	30%	Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs. **Note:** Please refer to the Outpatient Hospital/Facility Services or the Inpatient Hospital Services sections of this document for more details.	30%	Coinsurance after Deductible
Radiology Services (X-rays)	$65	Copayment per visit
Dental Services (Radiation therapy of cancer or neoplastic diseases of the head or neck)	$65	Copayment per visit
Laboratory Services	$40	Copayment per visit
Mental Health		
Outpatient Intensive Psychiatric Treatment Programs	30%	Coinsurance after Deductible
Dental & Orthodontic Services		
Dental Anesthesia (Medically Necessary)	$65	Copayment per visit
Orthodontic Services (Medically Necessary Services include: oral surgery due to trauma and reconstruction for cleft palate)	30%	Coinsurance
Temporomandibular Joint Syndrome (Medically necessary surgical and arthroscopic treatment)	30%	Coinsurance

Inpatient Hospital / Facility Services	At Participating Providers, You Pay	
Medical / Surgical		
Professional	30%	Coinsurance after Deductible
Facility	30%	Coinsurance after Deductible
Reconstructive Surgery	30%	Coinsurance after Deductible
Internally implanted devices (surgically implanted hearing devices/cochlear implants, pacemakers, intraocular lenses, hip joints etc.)	30%	Coinsurance after Deductible

Dental & Orthodontic Services		
Dental Anesthesia (Resulting from an underlying medical condition)	30%	Coinsurance after Deductible
Dental Trauma (Medically Necessary oral surgery due to injury and trauma)	30%	Coinsurance after Deductible
Cleft Palate (Medically Necessary reconstructive surgery)	30%	Coinsurance after Deductible
Maternity Care (Professional and Facility Services)	30%	Coinsurance after Deductible
Rehabilitative Services (**30** day limit per calendar year)	30%	Coinsurance after Deductible
Mental Health (Inpatient Psychiatric Hospitalization)	30%	Coinsurance after Deductible
Substance Use Disorders		
Inpatient Detoxification	30%	Coinsurance after Deductible
Transitional Residential Recovery Services	30%	Coinsurance after Deductible
Transplant Services	30%	Coinsurance after Deductible
Skilled Nursing Facility (limited to 60 days per calendar year) (Services must be billed by a Skilled Nursing Facility Participating Provider.)	30%	Coinsurance after Deductible
Long-Term Care Facility Following Hospitalization	30%	Coinsurance after Deductible
Hospice Care	No Charge	

Please refer to Prescription Drug Section for a description of Prescription Drug benefits.

Prescription Drug Coverage [4]	At Participating Providers, You Pay	
Retail Pharmacy Prescription Drugs		
Tier 1 Drugs	$10	Copayment
Tier 2 Drugs	$60	Copayment
Tier 3 Drugs	40% after Deductible	Coinsurance
Tier 4 Drugs	40% after Deductible	Coinsurance
Tier 5 Drugs	No Charge	

Prescription Drug Coverage [4]	At Participating Providers, You Pay	
Mail-order Prescription Drugs	A 90-day supply is offered at two times the 30- day retail prescription Cost Sharing. Depending on Tier level this will be either a copayment or a coinsurance.	
Tier 1 Drugs	$20	Copayment per visit
Tier 2 Drugs	$120	Copayment per visit
Tier 3 Drugs	26.67% after Deductible	Coinsurance
Tier 4 Drugs	Not available for mail order	
Tier 5 Drugs	No Charge	

[4]Please note, cost sharing reduction for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third party Cost-Sharing assistance, will not apply toward any Deductible, or the Annual Out-of-Pocket maximum under Your Plan.

Other Services	At Participating Providers, You Pay	
Durable Medical Equipment (Includes but not limited to: wheelchairs, scooters, and custom orthotics)	30%	Coinsurance
Home Healthcare (limited to 130 visits) (Services must be billed by a Home Healthcare agency that is a Participating Provider) (Separate Cost-Sharing may apply for other covered benefits delivered in the home setting, e.g. injectable drugs, durable medical equipment, etc.)	No Charge	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers. However, You may be responsible for provider charges that exceed the allowed amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.)	30%	Coinsurance
Other Services	**At Participating Providers, You Pay**	
Dialysis Services	$60	Copayment per visit
Infusion Therapy	30%	Coinsurance after Deductible

TABLE OF CONTENTS

Non-Discrimination Notification I
Non-Discrimination Tag Line– Section 1557 ii
TABLE OF CONTENTS 7
WELCOME 10
INTRODUCTION 10
DEFINITIONS 12
ELIGIBILITY AND ENROLLMENT 17
When Will My Molina Membership Begin? 17
Who is Eligible? 18
MEMBER IDENTIFICATION CARD 22
How do I Know if I am a Molina Healthcare Member? 22
Sample ID card 22
What Do I Do First? 22
YOUR PRIVACY 23
NOTICE OF PRIVACY PRACTICES 24
What can You do if Your rights have not been protected? 27
What are the duties of Molina Healthcare? 27
This Notice is Subject to Change 27
ACCESSING CARE 27
How Do I Get Medical Services Through Molina? 27
Out of Network Providers 28
Member Right to Obtain Health Care Services Outside of Policy 30
Changing Your Doctor 32
24-Hour Nurse Advice Line 34
Telehealth and Telemedicine Services 34
Prior Authorization 35
Standing Approvals 38
Second Opinions 38
Emergency And Urgent Care Services 39
What is an Emergency? 39
How do I get Emergency Care? 39
If You are away from Molina Healthcare’s Service Area and need Emergency Care? 39
What if You need after-hours care or Urgent Care Services? 39

Emergency Services by a Non-Participating Provider 40
Services of Specified Non-Contracted Hospital-Based Physician 40
Complex Case Management 41
Pregnancy 41
Access To Care For Members With Disabilities 42
COVERED SERVICES 42
Cost Sharing 42
Annual Out-of-Pocket Maximum 43
Coinsurance 43
Copayment 43
Deductible 43
General Rules Applicable to Cost Sharing 44
Receiving a Bill 44
What is Covered Under My Plan? 45
Preventive Care and Services 46
Preventive Services for Children and Adolescents 46
Preventive Services for Adults and Seniors 47
Habilitative Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 day(s)) 50
Rehabilitative Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 day(s)) 50
Outpatient Mental/Behavioral Health Services 50
Outpatient Substance Use/Chemical Dependency Services 51
Dental and Orthodontic Services 51
Pediatric Vision Services 52
Nutritional Counseling 54
Phenylketonuria (PKU) 54
Outpatient Hospital/Facility Services 54
Outpatient Surgery 54
Radiation Therapy for cancer 55
Specialized Imaging and Scanning Services 55
Radiology Services (X-Rays) 55
Laboratory Tests and Services 55
Mental/Behavioral Health 55
Inpatient Hospital Services 55
Medical/Surgical Services 56

Maternity Care 56
Mental/Behavioral Health Inpatient Psychiatric Hospitalization 57
Skilled Nursing Facility (60 days per calendar year) 58
Hospice Care 58
Alternative to Hospitalization or Inpatient care 59
Approved Clinical Trials 59
Reconstructive Surgery 60
Reconstructive surgery exclusions 61
Transplant Services 61
PRESCRIPTION DRUG COVERAGE 61
Durable Medical Equipment 69
Prosthetic and Orthotic Devices 69
Internally implanted devices 70
External devices 70
Home Health Care (up to 130 visits per year) 70
TRANSPORTATION SERVICES 71
Emergency Medical Transportation 71
Dialysis Services 71
Hearing Services 71
Services Provided Outside the United States (or Service Area) 75
Third-party liability 75
WORKERS' COMPENSATION 76
RENEWAL AND TERMINATION 76
How Does my Molina Healthcare Coverage Renew? 76
When Will My Molina Membership End? 76
PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT 78
Premium Notices/Termination for Non-Payment of Premiums 78
What if I have paid a medical bill or prescription? 82
How Does Molina Healthcare Pay for My Care? 82
GRIEVANCES AND APPEALS 87
What if I Have a Complaint (Grievance)? 88
Review of Adverse Benefit Determination 88
Internal Review of Adverse Benefit Determination 89
Expedited Review of Adverse Benefit Determination 89

External Review of Adverse Benefit Determination 91
MISCELLANEOUS PROVISIONS 92
Wellness Programs 93
HEALTH EDUCATION PROGRAMS 94

This Molina Healthcare of Washington, Inc. Agreement and Individual Policy (also called the "**Policy**" or "**Agreement**") is issued by Molina Healthcare of Washington, Inc. ("**Molina Healthcare**", "**Molina**", "**We**", "**Us**", or "**Our**"), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Molina agrees to provide the Covered Services as described in this Agreement.

This Agreement, and amendments to this Agreement, and any application(s) submitted to Molina and/or the Health Benefit Exchange to obtain coverage under this Agreement, including the applicable rate sheet for this Policy, are incorporated into this Agreement by reference, and constitute the legally binding contract between Molina and the Subscriber.

WELCOME

Welcome to Molina Healthcare!

Here at Molina, We will help You meet Your medical needs.

If You are a Molina Member, this Policy tells You what services You can get.

Molina Healthcare is a Washington licensed Health Maintenance Organization.

We can help You understand this Agreement. If You have any questions about anything in this Agreement, call Us. You can call if You want to know more about Molina. You can get this information in another language, large print, Braille, or audio. You may request a copy of the Policy, call or write to Us at:

Molina Healthcare of Washington, Inc.
Customer Support Center
P.O. Box 4004
Bothell, WA 90841

1 (888) 858-3492

If You are deaf or hard of hearing You may contact Us by dialing 711 for the Telecommunications Service or You may call Our dedicated TTY line toll- free at 1 (800) 735-2989.

INTRODUCTION

Thank You for choosing Molina Healthcare as Your health plan.

This document is called Your "Molina Healthcare of Washington, Inc. Agreement and Individual Policy" (Your "**Agreement**" or "**Policy**"). The Policy tells You how You can get services through Molina. It also sets out the terms and conditions of coverage under this Agreement. It tells You Your rights and responsibilities as a Molina Member. It explains how to contact Molina. Please read this Policy completely and carefully. Keep it in a safe place where You can get to it quickly. There are sections for special health care needs.

Molina Healthcare is here to serve You.

Call Molina if You have questions or concerns. Our helpful and friendly staff will be happy to help You.

We can help You with services such as:

- Arrange for an interpreter
- Check on Authorization Status
- Choose a PCP
- Make an appointment
- Make a Payment

We can also listen and respond to any of Your questions or grievances about Your Molina Policy.

Call Us toll-free at 1 (888) 858-3492 between 7:30 a.m. to 6:30 p.m. PT. We are here Monday through Friday. If You are deaf or hard of hearing, You may contact Us by dialing 711 for the Telecommunications Service or You may call Our dedicated TTY line toll- free at 1 (800) 735-2989.

Call the Health Benefit Exchange if You move from the address You had when You enrolled with Molina or if You change phone numbers.

DEFINITIONS

Some of the words used in this Policy do not have their usual meaning. Health plans use these words in a special way. When We use a word with a special meaning in only one section of this Policy, We explain what it means in that section. Words with special meaning used in any section of this Policy are explained in this "Definitions" section.

"**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Member's or applicant's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

"**Allowed Amount**" means the maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing.

Services obtained from a Participating Provider: This means the contracted rate for such Covered Services.

Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of 1) Molina's median contracted rate for such service(s), 2) 100% of the published Medicare rate for such service(s), or 3) Molina's usual and customary method for determining payment for such service(s).

"**Annual Out-of-Pocket Maximum**" (also referred to as **"OOPM"**) is the maximum amount of Cost Sharing You will have to pay for Covered Services in a calendar year. Cost Sharing includes payments You make toward any Deductibles, Copayments, or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the OOPM amount specified in the Schedule of Benefits, We will pay 100% of the charges for Covered Services for the remainder of the calendar year.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for individual Members and a separate OOPM amount for the entire family. If You are a Member in a family of two or more Members, You will meet the OOPM either:

1. when You meet the OOPM amount listed for an individual Member; or
2. when Your family meets the OOPM for the family.

If Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for every Member in Your family.

“**Child-Only Coverage”** means coverage under this Policy that is obtained by a responsible adult to provide benefit coverage only to a child under the age of 21.

“**Coinsurance**” is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina of Washington, Inc. Schedule of Benefits. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

“**Copayment**” is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

“**Cost Sharing**” is the Deductible, Copayment, and/or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits at the beginning of this Policy.

“**Covered Service”** or **“Covered Services**” refers to the healthcare services, including supplies and prescription drugs, that You are entitled to receive from Molina under this Policy.

“**Deductible**” is the amount You must pay in a calendar year for Covered Services You receive before Molina will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits Please refer to the Molina Healthcare of Washington, Inc. Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amount. Your Policy may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina covers services at “no charge” subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. However for preventive services covered by this Agreement and included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services when provided by a Participating Provider.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

- When You meet the Deductible for the individual Member; or
- When Your family meets the family Deductible.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible.

“**Dependent**” means a Member who meets the eligibility requirements as a Dependent, as described in this Policy.

“**Distant Site**” means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

“**Drug Formulary**” is Molina’s list of approved drugs that doctors can order for You.

“**Durable Medical Equipment**” is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to You in the absence of illness or injury and does not include accessories

primarily for Your comfort or convenience. Examples include, without limitation: oxygen equipment, blood glucose monitors, apnea monitors, nebulizer machines, insulin pumps, wheelchairs, and crutches.

"**Emergency**" or "**Emergency Medical Condition"** means the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity. Including severe pain, which the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person; or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"**Emergency fill**" means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where a patient presents at a contracted pharmacy with an immediate therapeutic need for a prescribed medication that requires a Prior Authorization.

"**Emergency Services**" means a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

"**Essential Health Benefits**" or "EHB" means a standardized set of essential health benefits that are required to be offered by Molina Healthcare to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services. This includes behavioral health treatment.
- Prescription drugs
- Rehabilitative and Habilitative services and devices
- Laboratory services
- Preventive and wellness services (including chronic disease management)
- Pediatric services, including dental* and vision care for Members under the age of 19

***Pediatric dental services are not covered under this Policy. These dental services can be separately obtained through a stand-alone dental plan certified by the Health Benefit Exchange.

"**Experimental or Investigational**" means any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are experimental or investigational, Molina will consider whether the services are in general use in the medical community in the State of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven safe and efficacious.

"**Health Benefit Exchange**" means a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Washington buy qualified health plan coverage from insurance companies or health plans such as Molina. The Health Benefit Exchange may be run as a state-based marketplace, a federally facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Health Benefit Exchange operating in the State of Washington, however; it may be organized and run.

“**Medically Necessary”** or “**Medical Necessity**” means health care services determined by a provider, in consultation with Molina Healthcare, to be clinically appropriate or clinically significant, in terms of type, frequency, event, site, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by Molina Healthcare consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

“Mental Health Services” has the meaning consistent with definitions in Title 48 RCW for Medically Necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American Psychiatric Association and any associated state or federal laws.

“**Molina Healthcare of Washington, Inc. (“Molina Healthcare”** or **“Molina”, “We”,** or **“Our”** or **“Us”) means** the corporation registered in Washington as a Health Maintenance Organization, and contracted with the Health Benefit Exchange.

“**Molina Healthcare of Washington, Inc. Agreement and Individual Policy”** means this booklet, which has information about Your benefits. It is also called the “Policy” or “Agreement”.

“**Member**” (also “**You**” or “**Your**”) means an individual who is eligible and enrolled under this Agreement, and for whom We have received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21. In which case, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Policy but will not be a Member.

“**Non-Participating Provider”** refers to those physicians, hospitals, and other providers that have not entered into contracts to provide Covered Services to Members.

“**Other Practitioner**” refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

"**Originating Site**" means the physical location of a patient receiving health care services through telemedicine. This includes a:

- Hospital;
- Rural health clinic;
- Federally qualified health center;
- Physician's or other health care provider's office;
- Community mental health center;
- Skilled nursing facility;
- Home or any location determined by the individual receiving the service;
- Renal dialysis center, except an independent renal dialysis center.

“**Participating Provider**” means a “**Provider**” who contracts with Molina or with Molina’s contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or Deductible, directly or indirectly, from the health maintenance organization. Your Provider network is Molina Marketplace. Your Molina Marketplace list of Participating Providers is available at: MolinaMarketplace.com.

"**Preexisting Condition Exclusion**" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

"**Premiums**" mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

"**Primary Care Doctor**" (also a "**Primary Care Physician**" and "**Personal Doctor**") is the doctor who takes care of Your health care needs. Your Primary Care Doctor has Your medical history. Your Primary Care Doctor makes sure You get needed health care services. A Primary Care Doctor may refer You to a Specialist Physician for other services. A Primary Care Doctor includes, but is not limited to, one of the following types of doctors:

- Family or general practice doctor who usually can see the whole family.
- Internal medicine doctor, who usually only see adults and children 14 years or older.
- Pediatrician, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

"Primary Care Provider" ("PCP") means:

- Primary Care Doctor, or
- An individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor, or
- Other Practitioner who within the scope of his or her license is authorized to provide primary care services.

"Prior Authorization" means Molina's prior determination for Medical Necessity of Covered Services, including certain prescription medications, before services are provided. Prior Authorization is not a guarantee of payment for services. Payment is made based upon the following; benefit limitations,

- exclusions ,
- Member eligibility at the time the services are provided and;
- other applicable standards during the claim review.

"Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

"**Referral**" means the process by which the Member's Primary Care Doctor directs the Member to seek and obtain Covered Services from other providers.

"**Service Area**" means the geographic area in Washington where Molina has been authorized by the Washington State Office of the Insurance Commissioner to market individual products sold through the Health Benefit Exchange, enroll Members obtaining coverage through the Health Benefit Exchange and provide benefits through approved individual health plans sold through the Health Benefit Exchange. The Service Area consists of Clark, Ferry, King, Klickitat, Lincoln, Mason, Pend Oreille, Pierce, Skamania, Spokane, Stevens, and Thurston Counties.

"**Specialist Physician**" means any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this Policy, the term "**Spouse**" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of

Washington law.

"**Subscriber**" means either: An individual who is a resident of Washington, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina in accord with the terms of this Agreement; or

- A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Agreement. By way of example only, where Subscriber will act as the legal representative of Member under this Agreement, "You" or "Your" shall mean Subscriber.

"Substance Use Disorder" has the meaning consistent with definitions in Title 48 RCW and WAC 284 for chemical dependency relating to an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by frequent or an intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially disrupted.

"Telehealth and Telemedicine Services" means:

- Delivery of Covered Services by a Participating Provider through audio and video conferencing technology that permits communication between a Member at an originating site and a Participating Provider at a distant site, allowing for the diagnosis or treatment of Covered Services.
- The communication does not involve in-person contact between the Member and a Participating Provider. During the virtual visit the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider.
- Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member's medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as "Store and Forward" technology). Requirement: When using "Store and Forward" technology, all covered services must also include an in-person office visit to determine diagnosis or treatment.

"**Urgent Care Services"** mean medically necessary health care services, facility costs, including supplies, provided in an Emergency or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention.

ELIGIBILITY AND ENROLLMENT

When Will My Molina Membership Begin?

Your coverage begins on the Effective Date. The Effective Date is the date You meet all enrollment and Premium pre-payment requirements.

For coverage during the calendar year 2019, the initial open enrollment period begins November 1, 2018, and ends December 15, 2018 Your Effective Date for coverage during 2019 will depend on when You apply and pay for your coverage:

- If You apply on or before December 15, 2018, the Effective Date of Your coverage is January 1,

2019.
- Applications made after December 15, 2018 are subject to Special Enrollment Period requirements and verification.

If You do not enroll during an open enrollment period, You may be able to enroll during a special enrollment period. You must be eligible under the special enrollment procedures established by the Health Benefit Exchange and your reason for eligibility must be verified with documentation. In such case, the Effective Date of coverage will be determined by the Health Benefit Exchange. Without limiting the above, the Health Benefit Exchange will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

The Effective Date for coverage of new Dependents is described below in the section titled "Adding New Dependents".

Who is Eligible?

To enroll and stay enrolled You must meet all of the eligibility requirements. These are set by the Health Benefit Exchange. Check the Health Benefit Exchange website at www.wahealthplanfinder.org for these requirements. For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. The "Special Enrollment Periods" section outlines the Special enrollment eligibility requirements. If You have lost Your eligibility, You may not be able to re-enroll, check with the Health Benefit Exchange for Special Enrollment eligibility. This is described in the section titled "When Will My Molina Membership End? (Termination of Covered Services)."

Molina Healthcare of Washington may not restrict You or Your eligible Dependents who are enrolled in this Policy from seeking medical treatment with a non-participating provider. However, should You or Your eligible Dependents who are enrolled in this Policy obtain medical treatment with a non-participating provider You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum for any of these services.

For exceptions please review the section of the Agreement titled "Emergency Services and Urgent Care Services", in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services", and for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?,"

Dependents: Subscribers who enroll in this Policy during the open enrollment period established by the Health Benefit Exchange may also apply to enroll eligible Dependents. This is established by the Health Benefit Exchange. Dependents must meet the eligibility requirements. The following family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's or Domestic Partner's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren generally do not qualify as Dependents of the Subscriber unless added as a newborn child of a covered Dependent child or of a Member covered by Child-Only Coverage under this Agreement. Coverage for children of a covered Dependent child or of a Member under a Child-Only Coverage will end when the covered Dependent child or Member under a Child-Only Coverage is no longer eligible under this Agreement.
- Domestic Partners: If permitted by the Health Benefit Exchange, a domestic partner of the Subscriber may enroll in this product. The domestic partner must meet any eligibility and verification of domestic

partnership requirements established by the Health Benefit Exchange.

Age Limit for Disabled or Handicapped Children: Children who reach age 26 are eligible to continue enrollment as a Dependent for coverage if each of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

Molina or the Health Benefit Exchange will provide the Subscriber with notice before the enrolled child reaches the limiting age. At this time, the Dependent child's coverage will end. The Subscriber must give Molina or the Health Benefit Exchange proof of his or her child's incapacity and dependence. This must happen within 31 days of the child's attainment of the limiting age and no more frequently than annually after first 2 years of attainment. This must occur in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina
A disabled child may remain covered by Molina as a Dependent. This applies as long as he or she remains incapacitated. The child must initially meet and continue to meet the above-described eligibility criteria.

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after You as the Subscriber or Member (in the case of Child-Only coverage) are enrolled (such as a new Spouse, a newborn child, newly adopted child, foster child), You must contact the Health Benefit Exchange and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to the Health Benefit Exchange within 60 days from the date the Dependent became eligible to enroll with Molina. Additional premium will be charged up to a maximum of three Dependents under age 21. All Dependents age 21 and over will be subject to additional premium as determined by the Health Benefit Exchange at the time of enrollment.

- **Spouse**: You can add a Spouse as long as You apply during the open enrollment period.
  You can also apply no later than 60 days after any event listed below:

  - The Spouse loses "minimum essential coverage" through:
  - Government sponsored programs,
  - Employer-sponsored plans,
  - Individual market plans, or
  - Any other coverage designated as "minimum essential coverage" in compliance with the Affordable Care Act.
  - The date of Your marriage.
  - The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **Children Under 26 Years of Age**: You can add a Dependent under the age of 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

  - The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act.
  - The child becomes a Dependent through marriage, birth, placement in foster care, adoption, placement for adoption, child support, or other court order.
  - The child, who was not previously a citizen, national, or lawfully present individual, gains such

status.
    - The child permanently moves into the service area.

- **Newborn Child**: Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth). Notify Molina within 60 days of any birth or adoption for enrollment. Additional premium will be charged up to a maximum of three dependents under the age of 21.

- **Adopted Child**: A newly adopted child or child placed with You or Your Spouse for adoption is covered from whichever date is earlier:

    - The date of adoption or placement for adoption, or when You or Your Spouse assume the legal obligation for total or partial support in anticipation of adopting the child, whichever is earlier. If You do not enroll the adopted child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days. This includes the date of adoption or placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier.

- Note: When do You need to notify Molina about coverage for Your newborn child or newly adopted child?
    - You only need to notify Molina within 60 days of any birth or adoption if payment of an additional premium is required to provide coverage for a child. Additional premium will be charged up to a maximum of three dependents under age 21. Dependents age 21 through 26 do not figure into the three dependent calculation.

- **Court Order to Provide Child Coverage**: If a child becomes a dependent of You or Your spouse through a child support order or other court order, then the child shall be eligible for coverage under this Agreement. A Dependent can be added to this Agreement during the open enrollment period or within 60 days of the effective date of the court order. The child shall be eligible for coverage on the date the court order is effective or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

- **Foster Child**: If a child is placed with You or Your spouse for foster care, then the child shall be eligible for coverage under this Agreement. A foster child can be added to this Agreement during the open enrollment period or within 60 days of the child's placement with You in foster care. The child's coverage shall be effective on the date of placement in foster care or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

Discontinuation of Dependent Covered Services:
Covered Services for Your Dependent will be discontinued on:

- The end of the calendar month that the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children Age Limit for Disabled or Handicapped Children".
- The date the Dependent Spouse enters a final decree of divorce, annulment, or dissolution of marriage from the Subscriber.
- End of the month that the child only Member is no longer eligible.

Special Enrollment Periods
A Qualified Individual has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

- A Qualified Individual or dependent loses minimum essential coverage;
- Loss of dependent coverage due to the death of a Qualified Individual
- Loss of Essential Minimum Coverage due to a Reduction in employment hours
- Loss of Essential Minimum Coverage due to the termination of a domestic partnership
- A Qualified Individual loses employer sponsored coverage for any reason except for misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage;
- A Qualified Individual experiences the loss of eligibility for Medicaid or a public program providing health benefits;
- A Qualified Individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption or placement for adoption;
- A Qualified Individual loses of coverage as the result of dissolution of marriage.;
- A Qualified Individual experiences a permanent change in Residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new Service Area or results in new eligibility for previously unavailable Qualified Health Plans;
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the Qualified Individual;
- Coverage is discontinued in a Qualified Health Plan by the Exchange pursuant to 45 C.F.R. 155.430 and the three month grace period for continuation of coverage has expired;
- Exhaustion of COBRA coverage due to failure of the employer to remit premium;
- Loss of COBRA coverage where the qualified individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;
- A Qualified Individual discontinues coverage under a health plan offered pursuant to the Washington State Health Insurance Coverage Access Act;
- A Qualified Individual loses coverage as a dependent on a group plan due to age;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month, without requiring an additional special enrollment triggering event;
- A Qualified Individual lost prior coverage due to errors by the Exchange staff or the U.S. Department of Health and Human Services;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- An enrollee demonstrates to the Exchange that the Qualified Health Plan in which he or she is enrolled violated a material provision of its Contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for Cost-Sharing Reductions, or the individual's dependent becomes newly eligible; or
- The individual or their dependent who is currently enrolled in employer sponsored coverage is determined to be newly eligible for Advanced Premium Tax Credits.

If the enrollee eligible for the special enrollment period had prior coverage, they will be offered the benefit packages available to individuals who enrolled during the open enrollment period within the same metal tier or level at which the enrollee had previously. Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. An eligible enrollee will not be required to pay more for coverage than a similarly situated individual who enrolls during open enrollment. An enrollee who was enrolled in a catastrophic plan as defined in RCW 48.43.005(8) may be limited to the plans available during open enrollment at either the bronze or silver level. An enrollee whose eligibility is based on their status as a dependent may be limited to the same metal tier for the plan on which the primary subscriber is enrolled.

The Exchange may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event. This section should not be interpreted to limit the Exchange's rights to automatically enroll qualified individuals based on good cause or exceptional circumstances as defined by the

Exchange or as required by the U.S. Department of Health and Human Services. Qualified Individuals that enroll between the first and twenty third day of the month will have a coverage Effective Date of the first day of the following month. Qualified Individuals that enroll between the twenty fourth and last day of the month will have a coverage Effective Date of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but advance payments of the premium tax credit and Cost-Sharing Reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, the beginning of a domestic partnership, or in the case where the Qualified Individual loses minimum essential coverage, the Effective Date is the first day of the following month. American Indians/Alaskan Natives eligible for services through an Indian Health Care Provider may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month. Please contact the Exchange for more information.

MEMBER IDENTIFICATION CARD

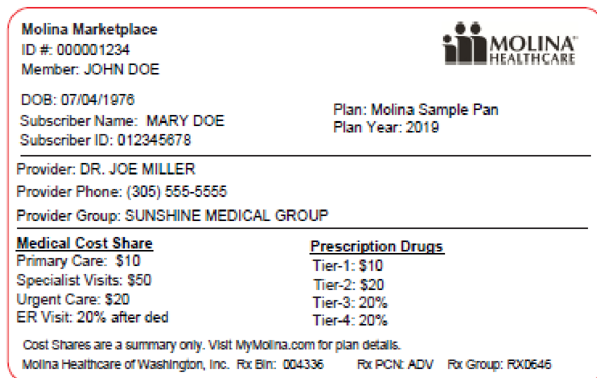
How do I Know if I am a Molina Healthcare Member?

You get a Member identification card (ID card) from Molina. Your ID card comes in the mail within 10 business days after You make Your first payment. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care services. If You lose Your ID card, call Molina toll-free at 1 (888) 858-3492. We will be happy to send You a new ID card.

If You have questions about how health care services may be obtained, You can call Molina's Customer Support Center toll-free at 1 (888) 858-3492.

Sample ID card

Front of card


Molina Marketplace
ID #: 000001234
Member: JOHN DOE

MOLINA HEALTHCARE

DOB: 07/04/1976
Subscriber Name: MARY DOE
Subscriber ID: 012345678

Plan: Molina Sample Pan
Plan Year: 2019

Provider: DR. JOE MILLER
Provider Phone: (305) 555-5555
Provider Group: SUNSHINE MEDICAL GROUP

Medical Cost Share
Primary Care: $10
Specialist Visits: $50
Urgent Care: $20
ER Visit: 20% after ded

Prescription Drugs
Tier-1: $10
Tier-2: $20
Tier-3: 20%
Tier-4: 20%

Cost Shares are a summary only. Visit MyMolina.com for plan details.
Molina Healthcare of Washington, Inc. Rx Bin: 004336 Rx PCN: ADV Rx Group: RX0646

Back of card

This card is for identification purposes only and does not prove eligibility for service.
Member: Emergencies (24 hrs): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
Miembro: Emergencias (24 horas al día): si una emergencia médica puede resultar en muerte o discapacidad, llame al 911 inmediatamente o acuda a la sala de emergencias más cercana. No necesita autorización previa para los servicios de emergencia.
Remit claims to: Molina Healthcare, P.O. Box 22612, Long Beach, CA 90801
Member Services: (888) 858-3492 (TTY/TTD: 711)
24 Hour Nurse Advice Line: (888) 275-8750
Línea de Consejos de Enfermeras 24 horas al día (español): (866) 648-3537
CVS Caremark Pharmacy Help Desk: (800) 364-6331
Provider: Notify the health plan within 24 hours of any inpatient admission at the hospital admission notification.
Prior Authorization/Notification of Hospital Admission and Covered Services: (855) 322-4082

MolinaMarketplace.com

What Do I Do First?

Look at Your Molina Healthcare Member ID card. Check that Your name and date of birth are correct. Your ID card will tell You the name of Your doctor. This person is called Your PCP. This is Your main doctor. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)

- Your date of birth (DOB)
- Your PCP's name (Provider)
- Your PCP's office phone number (Provider Phone)
- The name of the medical group Your PCP is associated with (Provider Group)
- Molina Healthcare's 24-hours Nurse Advice Line toll-free number 1 (888) 275-8750.
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- The toll-free number for prescription related questions (CVS Caremark Pharmacy Help Desk) : 1 (800) 364-6331
- The toll-free number for emergency rooms to notify Molina Healthcare of emergency room admissions for Our Members Emergencies (24 hrs.). When a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No Prior Authorization is required for emergency care.
- If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3492.

Your ID card is used by health care providers such as Your Primary Care Doctor, pharmacist, hospital and other health care providers to determine Your eligibility for services through Molina Healthcare. When accessing care You may be asked to present Your ID card before services are provided.

YOUR PRIVACY

Your privacy is important to Us. We respect and protect Your privacy. Molina Healthcare uses and shares Your information to provide You with health benefits. Molina Healthcare wants to let You know how Your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes Your name, member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run Our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for purposes not listed above.

What are Your privacy rights?

- To look at Your PHI
- To get a copy of Your PHI
- To amend Your PHI
- To ask Us to not use or share Your PHI in certain ways
- To get a list of certain people or places We have given Your PHI

How does Molina Healthcare protect Your PHI?
Molina Healthcare uses many ways to protect PHI across Our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use it.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina Healthcare secures PHI in Our computers. PHI in Our computers is kept private by using firewalls and passwords.

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. Our Notice of Privacy Practices is in the following section of this Policy and is on Our web site at MolinaMarketplace.com. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center at 1 (888) 858-3492.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF WASHINGTON, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Washington, Inc. ("**Molina Healthcare**", "**Molina**", "**We**", "**Us**", or "**Our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment, payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2014.

PHI stands for these words, protected health information. PHI means health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Your PHI?
We use or share Your PHI to provide You with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment
Molina Healthcare may use or share Your PHI to give You, or arrange for, Your medical care. This treatment also includes referrals between Your doctors or other health care providers. For example, We may share information about Your health condition with a Specialist Physician. This helps the Specialist Physician talk about Your treatment with Your doctor.

For Payment
Molina Healthcare may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, Your condition, Your treatment, and supplies given may be written on the bill. For example, We may let a doctor know that You have Our benefits. We would also tell the doctor the amount of the bill that We would pay.

For Health Care Operations

Molina Healthcare may use or share PHI about You to run Our health plan. For example, We may use information from Your claim to let You know about a health program that could help You. We may also use or share Your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help Us obey laws;
- Address Member needs, including solving complaints and grievances.

We will share Your PHI with other companies ("**business associates**") that perform different kinds of activities for Our health plan. We may also use Your PHI to give You reminders about Your appointments. We may use Your PHI to give You information about other treatment, or other health- related benefits and services.

When can Molina Healthcare use or share Your PHI without getting written authorization (approval) from You?

The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes including the following:

Required by law

We will use or share information about You as required by law. We will share Your PHI when required by the Secretary of the U.S. Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight

Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases.

Law Enforcement

Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence

Your PHI may be shared with legal authorities if We believe that a person is a victim of abuse or neglect.

Workers Compensation

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures
Your PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following:
(1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given Us. Your cancellation will not apply to actions already taken by Us because of the approval You already gave.

What are Your health information rights?
You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**
  You may ask Us not to share Your PHI to carry out treatment, payment or health care operations. You may also ask Us not to share Your PHI with family, friends or other persons You name who are involved in Your health care. However, We are not required to agree to Your request. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give You Your PHI in a certain way or at a certain place to help keep Your PHI private. We will follow reasonable requests, if You tell Us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by Us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases We may deny the request.

- **Amend Your PHI**
  You may ask that We amend (change) Your PHI. This involves only those records kept by Us about You as a Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. You may file a letter disagreeing with Us if We deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that We give You a list of certain parties that We shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:

  - For treatment, payment or health care operations;
  - To persons about their own PHI;
  - Sharing done with Your authorization;
  - Incident to a use or disclosure otherwise permitted or required under applicable law;
  - As part of a limited data set in accordance with applicable law.

What can You do if Your rights have not been protected?

You may complain to Molina Healthcare and to the U.S. Department of Health and Human Services if You believe Your privacy rights have been violated. We will not do anything against You for filing a complaint. Your care and benefits will not change in any way.
You may complain to Us at:

Customer Support Center
P.O. Box 4004
Bothell, WA 98041
1 (888) 858-3492

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

TDD 1 (800) 537-7697
FAX 1 (206) 615-2297

What are the duties of Molina Healthcare?

Molina Healthcare is required to:

- Keep Your PHI private;
- Give You written information such as this on Our duties and privacy practices about Your PHI;
- Provide You with a notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this Notice at any time. If We do, the new terms and practices will then apply to all PHI We keep. If We make any material changes, Molina will post the revised Notice on Our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in Our next annual mailing to Our
Members then covered by Molina.

Contact Information:
If You have any questions, please contact the following office:

Customer Support Center
P.O. Box 4004
Bothell, WA 90841
1 (888) 858-3492

ACCESSING CARE

How Do I Get Medical Services Through Molina?

(Choice of Doctors and Participating Providers; Facilities)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE SERVICES MAY BE OBTAINED.

Your Participating Provider Directory includes a list of the PCPs and hospitals that are available to You as a Member of Molina. You may visit Molina's website at MolinaMarketplace.com to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy.

Except for Emergency Services, and as otherwise noted in this document, You must receive Covered Services from participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment to non-Participating Providers and the payments will not apply to the Deductible or Out-of-Pocket Maximum.

In general, the first person You should call for any health care is Your PCP; however, You may visit another Participating Provider instead of Your PCP, and a referral is not required.

If You need hospital or similar services, You must go to a Health Care Facility that is a Participating Provider. For more information about which facilities are with Molina or where they are located, call Molina toll-free at 1 (888) 858-3492. You may get Emergency Services in any emergency room.

Out of Network Providers

In general, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum. However, You may receive services from a Non-Participating Provider for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services". For additional exceptions see the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

This chart is to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. The right side tells You who to call or where to go.

ALWAYS CONSULT YOUR PCP FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALISTS OR OTHER PRACTITIONER CARE.	
TYPE OF HELP YOU NEED:	**WHERE TO GO. WHOM TO CALL.**
Emergency Services	Call **911** or go to the nearest emergency room. Even when outside Molina's network or Service Area, please call **911** or go to the nearest emergency room for Emergency Services.
Urgent Care Services	Call Your PCP or Molina's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. Urgent Care Services are only covered when You are seen by a Participating Provider. If you are out of area and require Urgent Care Services go to the nearest emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
To see an OB/GYN (woman's doctor)	Women may go to any Participating Provider OB/GYN without a referral or Prior Authorization. Ask Your doctor or call Molina's Customer Support Center if You do not know an OB/GYN.
For mental health or substance use evaluation	Go to a mental health or substance use Participating Provider. You do not need a referral or Prior Authorization to get a mental health or substance use evaluation.
For mental health or substance use therapy	Go to a mental/behavioral health or substance use Participating Provider. You do not need a referral. You do not need a Prior Authorization for outpatient

	office visits.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to a Specialist Physician who is a Participating Provider. A referral from Your PCP is not required. If You need Emergency Services or Urgent Care Services, get help as directed under "Emergency Services" or "Urgent Care Services" above.
To have surgery	Go to Your PCP first, or go to any Participating Provider of Your choice. If You need Emergency Services or Urgent Care Services, get help as directed under "Emergency Services" or "Urgent Care Services" above.
To get a second opinion	Consult Molina's Provider Directory on Our website at MolinaMarketplace.com/ to find a Participating Provider for a second opinion.
To go to the Hospital	If You need Emergency Services or Urgent Care Services, get help as directed under "Emergency Services" or "Urgent Care Services" above. For non-emergency, go to Your PCP first, or go to any hospital facility that is a Participating Provider.
After-hours care	You can call Molina's Nurse Advice Line. • Toll-free 1 (888) 275-8750 • Spanish 1 (866) 648-3537

Member Right to Obtain Health Care Services Outside of Policy
Molina does not restrict You from freely contracting at any time to obtain any health care services outside the health care Policy on any terms or conditions You choose. However, You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum for any of these services.

For exceptions please review the section of the Agreement titled "Emergency Services and Urgent Care Services", and for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?,"

What is a Primary Care Provider (PCP)?
A Primary Care Provider (PCP) takes care of Your health care needs. A PCP knows You well. Call Your PCP when You are sick and You do not know what to do. You do not have to go to the emergency room unless You believe You have an Emergency Condition.

You may think that You should not see Your PCP until You are sick. That is not true.

Get to know Your PCP even when You are well. Go for yearly check-ups to stay healthy. Go to Your PCP for check-ups, tests and test results, shots, and when You are ill. Seeing Your PCP for check-ups allows problems to be found early. If You need special care, Your PCP will help You get it. Your PCP and You work together to keep You healthy.

If You want to know more about Your PCP or other Molina doctors, call Us. Molina's Customer Support Center number is toll-free at 1 (888) 858-3492.

Choosing Your Doctor (Choice of Physician and Providers)
Molina Marketplace network provides Participating Provider services under this Policy. For Your healthcare to be covered under this Policy, Your health care services must be provided by Molina Healthcare Participating Providers (doctors, hospitals, Specialist Physicians, Other Practitioner, or medical clinics), except in the case of Emergency Services . Please see section titled Emergency and Urgent Care Services for more information about the coverage of Emergency Services Participating Provider Urgent Care Services. If Medically Necessary Covered Services are not reasonably available through a Participating Provider, You may request Prior Authorization to allow referral to a Non-Participating Provider for the specifically requested medical condition. Upon Medical Necessity review, approved authorizations will be treated as a Participating Provider Covered Service and You will be responsible for In Network Cost Sharing associated with the service. See Schedule of Benefits for specific Cost Share. We will reimburse the Non-Participating Provider a negotiated rate for such services.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and hospitals that are available under Molina's health plan. You will also learn some helpful tips on how to use Molina's services and benefits. Visit Molina's website at MolinaMarketplace.com to view Our online list of participating providers, or call Molina Healthcare toll-free at 1 (888) 858-3492 to receive a printed copy.

You can find the following in Molina's Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Professional qualifications (e.g. board certification)
- You can also find out if a Participating Provider is taking new patients. This includes doctors, hospitals, Specialist Physicians, or medical clinics.

Note: Some hospitals and participating providers may not provide some of the services that may be covered under this Policy that You or Your family member might need. This may include family planning, all women's contraceptive drugs, devices and products approved by the FDA, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should get more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1 (888) 858-3492 to make sure that You can get the health care services that You need.

How Do I Choose a Primary Care Provider (PCP)?
It is easy to choose a Primary Care Provider (PCP). Simply use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or, You may want to choose one doctor for You and another one for Your family members. If You have a chronic, disabling or life-threatening illness, You may want to ask Molina Healthcare to allow You to use a non-primary care Specialist Physician as Your PCP. Contact Our Customer Support Center toll-free at 1 (888) 858-3492 to obtain the form to submit to Molina Healthcare. Molina Healthcare will approve or deny Your request within 30 days after receiving the written request. If the request is denied, You may appeal the denial through Molina Healthcare's complaint and appeal process.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You choose a PCP that You feel comfortable with. If You are female, You may, but are not required to, choose an OB/GYN (woman's doctor) to be Your PCP, and You may choose a pediatrician to be Your children's PCP.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina toll-free at 1 (888) 858-3492. Molina can also help You find a PCP. Tell Us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina doctor.

What if I Don't Choose a Primary Care Provider (PCP)?
Molina asks that You select a PCP within 30 days of joining Molina. However, if You do not choose a PCP, We will choose one for You.

Changing Your Doctor

What if I Want to Change my Primary Care Provider (PCP)?
You can change Your PCP at any time. The change will become effective no later than the beginning of the month following the request for the change. First visit Your doctor. Get to know Your PCP before changing. A good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina doctor.

Can my Primary Care Provider (PCP) request that I change to a different Primary Care Provider (PCP)?

Your PCP may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor-patient relationship breakdown

How do I Change my Primary Care Provider (PCP)?
Call Molina Healthcare toll-free at 1 (888) 858-3492. We are here Monday through Friday, 7:30 a.m. to 6:30 p.m. PT. You may also visit Molina's website at MolinaMarketplace.com to view Our online list of doctors. Let Us help You make the change. Sometimes You may not be able to get the PCP You want. This may happen because:

- The PCP is no longer a Participating Provider with Molina Healthcare.
- The PCP already has all the patients he or she can take care of right now.

What if my doctor or hospital is not with Molina?
If Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina Healthcare, We will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. Our Molina Healthcare Customer Support Center staff can help You make a choice.

If You are assigned to a PCP or hospital that is ending a contract with Molina Healthcare, then Molina Healthcare will provide You written notice of such a contract ending between Molina Healthcare and PCP or acute care hospital.

Continuity of Care

If You are receiving active treatment for covered services from a Participating Provider, who's participation with Molina is ending without cause, You may have a right to continue receiving covered services from that provider until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing.

An “Active Course of Treatment” is:

1) An ongoing course of treatment for a life-threatening condition;
2) an ongoing course of treatment for a serious acute condition;
3) the second or third trimester of pregnancy; or
4) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes

A “Life-Threatening Condition” is:

- a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

A “Serious Acute Condition” is:

- a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy.

Continuity of care will end when the earliest for the following conditions have been met:

- Upon successful transition of care to a Participating Provider
- Upon completion of the course of treatment prior to the 90th day of Continuity of Care
- After the 89th day of Continuity of Care
- If You have exceeded the benefit limits under Your plan
- If care is not medically necessary
- If care is excluded from your coverage
- If you become ineligible for coverage

We will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition. Unless otherwise required by law, Molina will reimburse the provider up to the previously contracted amount for such service. Except when these Continuity of Care services are provided by a PCP whose contract with Molina is terminating, You may be responsible to the provider for any billed amounts that exceed the amount paid by Molina under this section. That would be in addition to any in-network Cost-Sharing amounts that You owe under this Policy. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Your Deductible or Your Annual Out-of-Pocket Maximum.

We will not provide coverage for services not otherwise covered under this EOC.

Transition of Care

If You are new to Molina, We may allow You to continue receiving Covered Services for an ongoing course of treatment with a Non-Participating Provider until we arrange transition of care to a Participating Provider, under the following conditions:

1. Molina will only extend coverage for Covered Services to Non-Participating Providers, when it is determined to be Medically Necessary, through Our Prior Authorization review process. You may contact Molina to initiate Prior Authorization review.

2. Molina provides Covered Services on or after Your effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina), may be responsible for coverage until Your coverage is effective with Molina.

3. After Your effective date with Molina, We may coordinate the provision of Covered Services with any Non-Participating Provider (physician or hospital) on Your behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

4. For Inpatient Services: With Your assistance, Molina may reach out to any prior Insurer (if applicable) to determine Your prior Insurer's liability for payment of Inpatient Hospital Services through discharge of any Inpatient admission. If there is no transition of care provision through Your prior Insurer or You did not have coverage through an Insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of Your coverage with Molina, not prior.

What If There Is No Participating Provider to Provide a Covered Service?
If there is no Participating Provider that can provide a non-Emergency Covered Service, We will provide the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the same Covered Services when rendered by Participating Providers, provided You obtain Prior Authorization before the initiation of the service. In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances.

Please contact Us toll-free at 1 (888) 858-3492 between 7:30 a.m. to 6:30 p.m. PT Monday through Friday. If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line. The toll-free number is 1 (800) 735 - 2989.

24-Hour Nurse Advice Line

If You have questions or concerns about You or Your family's health, call Our 24-Hour Nurse Advice Line at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537. If You are deaf or hard of hearing, You can access Nurse Advice with the Telecommunications Service by dialing 711. Registered Nurses staff the Nurse Advice Line. They are open 24 hours a day, 365 days a year.

Your doctor's office should give You an appointment for the listed visits in this time frame:

Appointment Type For PCPs	When You should get the appointment
Emergency care	Available 24 hours / 7 days
Urgent care	Within 48 hours of the appointment request
Preventive care – non-urgent	Within 30 calendar days of request
Routine or non-urgent care appointments	Within 10 calendar days of request
After-hours care	Available 24 hours / 7 days
Office waiting time	Should not exceed 30 minutes

Telehealth and Telemedicine Services

You may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. For more information, please refer to Telehealth and

Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include facsimile, texting or email only.
- Member cost sharing associates to the Schedule of Benefits, based upon the Participating Provider's designation for Covered Services. (i.e. Primary Care, Specialist or Other Practitioner).
- Covered Services provided through Store and Forward technology must include an in-person office visit to determine diagnosis or treatment.

Prior Authorization

What is a Prior Authorization?

A **Prior Authorization** is an approval from Molina which confirms that a requested health care service, treatment plan, prescription drug or item of durable medical equipment has been determined to be Medically Necessary and is covered under Your plan .Molina's Medical Directors work in collaboration with participating providers to assure clinically appropriate or clinically significant care is delivered to our members, in terms of the type, frequency, event, or service site of care, according to generally accepted applicable practice guidelines. They decide on the Medical Necessity before the care or service is given. This is to ensure you receive the right care for Your specific condition. Within thirty days of receiving a request, Molina will furnish its medical necessity criteria for medical/surgical benefits and mental health/substance use disorder benefits or for other essential health benefit categories to an enrollee or provider when requested.

You do not need Prior Authorization for the following services:

- Diagnosis or treatment plan for Autism Spectrum Disorder*
- Dialysis (notification only; Prior Authorization is not required; please notify Molina before services are rendered by calling 1 (888) 858-3492
- Emergency or Participating Provider Urgent Care Services
- Family planning services
- Hospice care (notification only; Prior Authorization is not required; please notify Molina before services are rendered by calling 1 (888) 858-3492)
- Human Immunodeficiency Virus (HIV) testing & counseling
- Mental health outpatient services including;
  - Behavioral health treatment for PDD/autism (Applied Behavioral Analysis)
  - Day treatment
  - Health treatment rendered by a state hospital if the enrollee or covered dependent is involuntarily committed
  - Outpatient individual and group mental health evaluation and treatment
  - Medical evaluation of Mental Disorders
  - Outpatient psychotherapy and Intensive Outpatient Program (IOP) services
- Office-based procedures
- Outpatient rehabilitative services
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
- Please note that while outpatient occupational therapy, outpatient physical therapy outpatient speech therapy do not require a Prior Authorization these services are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

- Pregnancy and delivery (notification only; Prior Authorization is not required; please notify Molina before services are rendered by calling 1 (888) 858-3492)
- Services for sexually transmitted diseases
- Certain sleep studies (home based)
- Substance use outpatient services including;
    - day treatment
    - health treatment rendered by a state hospital if the enrollee or covered dependent is involuntarily committed
    - Outpatient services for the purposes of drug therapy
    - Outpatient individual and group substance use counseling
    - Medical treatment for withdrawal symptoms
    - Individual substance use evaluation and treatment
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- To self-refer to a participating OB/GYN

You must get Prior Authorization for the following services, except for Emergency Services or Participating Provider Urgent Care Services:

- Admission in a hospital or ambulatory care center for dental care.
- All inpatient admissions
- Ambulatory Surgery Center service (ASC)*
- Any kind of wheelchair
- Any other services listed as needing Prior Authorization in this Policy
- Certain outpatient hospital service*
- Certain prescription drugs**
- Cosmetic, plastic and reconstructive procedures (in any setting)
- Custom orthotics, custom prosthetics, braces, and splints. Examples are:
    - Implanted hearing device
    - Shoes or shoe supports
    - Special braces
- Diagnosis of infertility
- Drug quantities that exceed the day-supply limit
- Durable Medical Equipment*
- Certain Experimental and Investigational procedures
- General anesthesia for dental care in Members 7 years old or older
- Habilitative Services – After initial evaluation plus six (6) consecutive visits for outpatient and home settings
- Home health care - After initial evaluation plus six (6) consecutive visits for home settings
- Hyperbaric Therapy
- Imaging and special tests Examples are:
    - CT (computed tomography)
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiogram)
    - PET (positron emission tomography) scan
- Injectable drugs and medications not listed on the Molina Drug Formulary*
- Low vision follow-up care
- Mental Health Services: *
    - Crisis stabilization in a residential setting
    - Electroconvulsive Therapy (ECT),

    - Mental Health Inpatient,
    - Neuropsychological and psychological testing (first two visits do not require Prior Authorization)
    - Partial hospitalization
    - Residential treatment
    - Behavioral health treatment for PDD/autism
    - Transcranial magnetic services
    - Habilitative services
- Non-Emergent air ambulance
- Non-Participating Provider services
- Out of network Urgent Care Services
- Pain management care and procedures
- Radiation therapy and radio surgery
- Rehabilitative services
    - Aural Therapy (After initial evaluation plus six (6) consecutive visits for outpatient and home settings)
    - Cardiac and pulmonary rehabilitation
    - Inpatient speech Therapy
- Scooters
- Specialty pharmacy drugs (oral and injectable)
- Substance Use Services:*
    - Inpatient Services
    - Partial hospitalization
    - Detoxification Services
    - Transitional Substance Use
- Transplant evaluation and related service including Solid Organ and Bone Marrow (Cornea transplant does not require authorization)
- Unlisted and miscellaneous medical codes
- Wound Therapy

*Call Molina's Customer Support Center at 1 (888) 858-3492 if You need to find out if Your service needs Prior Authorization.

** For a list of covered medications You may review our formulary at MolinaMarketplace.com.

Molina Healthcare might deny a request for a Prior Authorization. You may appeal that decision as described below. If You and Your Participating Provider decide to proceed with service that has been denied Policy, You may have to pay the cost of those services.

Approvals are given based on Medical Necessity. We are here to help You, if You have questions about how a certain service is approved, call Us at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the Telecommunications Service.

We can explain to You how that type of decision is made. We will send You a copy of the approval process if You request it.

You may call Molina Healthcare at 1 (888) 858-3492 to request Prior Authorization. An expedited review of a Prior Authorization can be requested for an intervention, care or treatment where passage of time without treatment would, in the judgment of Your provider, would result in an imminent emergency room visit or hospital admission and deterioration of Your health status. Molina will make a determination on an expedited review request within two calendar days of receipt of all necessary information. For standard pre-service and

concurrent care requests, the Prior Authorization requests will be processed within five calendar days from Molina's receipt of the request.

If additional information is needed to make the Prior Authorization determination, Molina will approve or deny the request within four calendar days of the receipt of the additional information. We will deny a Prior Authorization if information We request is not provided to us. Expedited Prior Authorization requests related to medical conditions that may cause a serious threat to Your health are processed within 2 calendar days. This is 2 calendar days from when We get the information We need and ask for to make the decision. In the event that the expedited Prior Authorization request is also a concurrent review request, Molina will make a determination as soon as possible and no later than 24 hours after receipt, provided that the Prior Authorization request is made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments. For post-service review requests, Molina will make its determination within thirty calendar days. We will deny a Prior Authorization if information We request is not provided to Us within the required timeframe.

If a service request is not Medically Necessary, it may be denied. If it is not a Covered Service it may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are in the section "Grievances and Appeals".

Standing Approvals

You may have a condition or disease that requires special medical care over a long period of time. You may need a standing approval.

Your condition or disease may be life threatening. It may worsen. It could cause disability. If this is true You may need a standing approval to see a specialist physician. You may need one for a specialty care center, who has the expertise to treat Your condition.

To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina's doctors and specialist physicians to be sure Your treatment plan meets Your medical needs. If You have trouble getting a standing approval, call Us. The number is toll-free 1(888) 858-3492. For deaf or hard of hearing dial 711 for the Telecommunications Service.

If You feel Your needs have not been met please see Molina's grievance process. These instructions are in the "Grievances and Appeals" section.

Second Opinions

You or Your PCP may want a second doctor to review Your condition. This can be a PCP or a specialist physician. This doctor looks at Your medical record. The doctor may see You at their office. This new doctor may suggest a plan of care. This is called a second opinion. Please consult Your Participating Provider Directory on Our website. You can find a Participating Provider for a second opinion. Go to MolinaMarketplace.com and click Find a Provider.

Here are some reasons why You may get a second opinion:

- Your symptoms are complex or confusing.
- Your doctor is not sure the diagnosis is correct.
- You have followed the doctor's plan of care and Your health has not improved.
- You are not sure if You need surgery.
- You do not agree with what Your doctor thinks is Your problem.
- You do not agree with Your doctor's plan of care.
- Your doctor has not answered Your concerns about Your diagnosis or plan of care.
- There may be other reasons. Call Us if You have questions.

Emergency And Urgent Care Services

What is an Emergency?
Emergency Services are services needed to observe, evaluate, stabilize or treat an Emergency Medical Condition. An Emergency Condition includes:

- A medical condition with acute and severe symptoms. This includes severe pain.
- A psychiatric condition with acute and severe symptoms.
- Active labor.

If medical attention is not received right away, an Emergency could result in:

- Placing the patient's health in serious danger.
- Serious damage to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Disfigurement to the person.

Emergency Care also includes Emergency contraceptive drug therapy.

How do I get Emergency Care?
Emergency care is available 24 hours a day, seven days a week for Molina Members. If You think You have an Emergency:

- Call 911 right away.
- Go to the closest hospital or emergency room.

When You go for Emergency health care services, bring Your Molina Member ID card. The Emergency Room Copayment cost Share will be identified on Your Molina member ID card.

If You are not sure if You need Emergency care but You need medical help, call Your PCP. Or call Our 24-Hour Nurse Advice Line toll-free.

- English - 1 (888) 275-8750
- Spanish - 1 (866) 648-3537

The Nurse Advice Line is staffed by registered nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing please use the Telecommunications Service by dialing 711.

Please do not go to a hospital emergency room if Your condition is not an Emergency.

If You are away from Molina Healthcare's Service Area and need Emergency Care?
Go to the nearest emergency room for care. Please contact Molina within 24 hours or as soon as You can. Call toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the Telecommunication Service. When You are away from Molina's Service Area only Emergency Services are covered.

What if You need after-hours care or Urgent Care Services?
Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. You must get Urgent Care Services from a Participating Provider. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services call Your PCP or Molina's 24-Hour Nurse Advice Line. The number is toll-free.

- English 1 (888) 275-8750
- Spanish 1 (866) 648-3537

Our nurses can help You any time of the day or night. They will help You decide what to do. They can help You decide where to go to be seen.

If You are within Molina's Service Area You can ask Your PCP what Participating Provider urgent care center to use. It is best to find out the name of the Participating Provider urgent care center ahead of time. Ask Your doctor for the name of the Participating Provider urgent care center and the name of the hospital that You are to use.

If You are outside of Molina's Service Area You may go to the nearest emergency room.

You have the right to interpreter services at no cost. To help in getting after-hours care call toll-free at 1 (888) 858-3492.

Emergency Services by a Non-Participating Provider
Emergency Services for treatment of an Emergency Medical problem are subject to cost sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Schedule of Benefits.

Important: Except as otherwise required by state law, when Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, Molina will calculate the Allowed Amount as the greatest of the following:

1) Molina's Allowed Amount for such services,

2) Molina's median contracted rate for such services, or

3) 100% of the Medicare rate for such services.

Because Non-Participating Providers are not in Molina's contracted provider network, they may balance-bill You for the difference between Our allowed amount, described above, and the rate that they charge. You will be responsible for charges that exceed the allowed amount covered under this benefit.

Services of Specified Non-Contracted Hospital-Based Physician
In the event You receive non-emergency care from a hospital-based Non-Participating Provider who is delivering services in a Participating Provider hospital, Molina shall pay as long as the care is:

- Medically Necessary
- Prior Authorized
- A Covered Service

The Non-Participating Providers delivering services in a Participating Provider hospital may include, but are not limited to, pathologists, radiologists, and anesthesiologists.

Molina will determine the allowed amount covered for these services up to the lesser of any negotiated rate or Molina's median contracted rate in compliance with state law. That amount is subject to any applicable Deductible and/or Coinsurance for inpatient and/or outpatient professional services described in the Schedule of Benefits.

Mandatory Transfer to a Participating Provider Hospital

You must have a Prior Authorization to get hospital services, except in the case of Emergency Services. If You get services in a hospital or You are admitted to the hospital for Emergency Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

If Your Provider determines You are stable for transfer and Molina arranges for your transfer to a Participating Provider facility, and if you refuse the transfer, additional services provided in at the Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of- Pocket.

Complex Case Management

What if I have a difficult health problem?
Living with health problems can be hard. Molina has a program that can help. The Complex Case Management program is for Members with difficult health problems. It is for those who need extra help with their health care needs.

The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems. The nurse can teach You how to manage them. The nurse may also work with Your family or caregiver to make sure You get the care You need. The nurse also works with Your doctor. There are several ways You can be referred for this program. There are certain requirements that You must meet. This program is voluntary. You can choose to be removed from the program at any time.

If You would like information about this program, please call the Customer Support Center toll free. The number is 1 (888)858-3492. Deaf or hard of hearing dial 711 for the Telecommunications Service.

Pregnancy

What if I am pregnant?
If You are pregnant, or think You are pregnant, or as soon as You know You are pregnant, please call for an appointment to begin Your prenatal care. Early prenatal care is very important for the health and well- being of You and Your baby.

You may choose any of the following for Your prenatal care:

- Advanced Registered Nurse Practitioner Specialist (trained in women’s health and midwifery)
- Physician
- Physician Assistant
- Licensed Midwives
- Licensed Obstetrician-gynecologists (OB/GYNs)

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits, You must pick an OB/GYN or Certified Nurse Practitioner or Other Practitioner who is a Participating Provider.

Access To Care For Members With Disabilities

Americans with Disabilities Act
The Americans with Disabilities Act (ADA) prohibits discrimination based on disability. The ADA requires Molina and its contractors to make reasonable accommodations for patients with disabilities.

Physical Access
Molina Healthcare has made every effort to ensure that Our offices and the offices of Molina Healthcare doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Molina Healthcare toll-free at 1 (888) 858-3492 or call Our dedicated TTY line toll- free at 1 (800) 735-2989 and a Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing
Let Us know if You need a sign language interpreter at the time You make Your appointment. Molina Healthcare requests at least 72 hours advance notice to arrange for services with a qualified interpreter. Call Molina's Customer Support Center through the Telecommunication Service by dialing 711.

Access for Persons with Low Vision or who are Blind
This Policy and other important plan materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available and this Policy is also available in an audio format. For accessible formats, or for direct help in reading the Policy and other materials, please call Molina toll-free at 1 (888) 858-3492. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Molina's Customer Support Center.

Disability Access Grievances
If You believe Molina or its doctors have failed to respond to Your disability access needs, You may file a grievance.

COVERED SERVICES

Molina covers the services described in the section titled "What is Covered Under My Plan?" below. These services are subject to the exclusions, limitations, and reductions set forth in this Policy, only if all of the following conditions are satisfied:

- You are a Member on the date that You receive the Covered Services
- Except for preventive care and services, the Covered Services are Medically Necessary
- The services are listed as Covered Services in this Policy, inclusive of applicable services required by state and federal law.
- You receive the Covered Services from Participating Providers inside Our Service Area for this Policy offered through the Health Benefit Exchange, except where specifically noted to the contrary in this Policy. For example, in the case of an Emergency, You may receive covered services from outside providers.
- We cover Medically Necessary services for the treatment of congenital anomalies from the moment of birth.

The services Molina Healthcare covers under this Policy are those described in this Policy and inclusive of applicable state and federal laws, subject to any exclusions, limitations, and reductions described in this Policy.

Cost Sharing

(Money You Will Have To Pay To Get Covered Services)
Cost Sharing is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this

Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits at the beginning of this Policy.

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits. The Affordable Care Act requires preventive services. They will be provided by Participating Providers. Cost Sharing for Covered Services is listed in the Molina of Washington, Inc. Schedule of Benefits at the beginning of this Policy. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members. This is determined by the Health Benefit Exchange's rules.

For laboratory and diagnostic x-ray services that are provided in a PCP's or Specialist's office, on the same date of service as a PCP or Specialist office visit, You will only be responsible for the applicable Cost Sharing amount for the office visit. Laboratory and x-ray Cost-Sharing, as shown in the Schedule of Benefits, will apply if services are provided by a Participating Provider at a separate location, even if on the same day as an office visit.
YOU SHOULD REVIEW THE MOLINA HEALTHCARE OF WASHINGTON, INC. SUMMARY OF BENEFITS CAREFULLY. YOU NEED TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

Also referred to as "**OOPM**" this is the maximum amount of Cost Sharing You will have to pay for Covered Services in a calendar year. Cost Sharing includes payments You make toward any Deductibles, Copayments, or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the OOPM amount specified in the Schedule of Benefits, We will pay 100% of the charges for Covered Services for the remainder of the calendar year.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for individual Members and a separate OOPM amount for the entire family. If You are a Member in a family of two or more Members, You will meet the OOPM either:

1) when You meet the OOPM amount listed for an individual Member; or
2) when Your family meets the OOPM for the family

If Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for every Member in Your family.

Coinsurance

Coinsurance is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Some Covered Services do not have Coinsurance. They may apply a Deductible or Copayment.

Copayment

A Copayment is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Some Covered Services do not have a Copayment. They may apply a Deductible or Coinsurance.

Deductible

A Deductible is the amount You must pay in a calendar year for Covered Services You receive before Molina will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Please refer to the Molina Healthcare of Washington, Inc. Schedule of Benefits to see what Covered Services are subject to the Deductible and the

Deductible amount. Your Policy may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible when provided by a Participating Provider.

When Molina covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

- When You meet the Deductible for the individual Member; or
- When Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible

General Rules Applicable to Cost Sharing

All Covered Services have a Cost Sharing, unless specifically stated, or You meet the Annual Out-of-Pocket Maximum. Please refer to the Molina Healthcare of Washington, Inc. Schedule of Benefits at the beginning of this Policy. You will be able to determine the Cost Sharing amount You will be required to pay for each type of Covered Service listed.

You are responsible for the Cost Sharing in effect on the date You receive Covered Services, except as follows:

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this Policy, You pay the Cost Sharing in effect on Your admission date. You will pay this Cost Sharing until You are discharged. The services must be covered under Your prior health plan Policy. You must also have had no break in coverage. However, if the services are not covered under Your prior health plan Policy You pay the Cost Sharing in effect on the date You receive the Covered Services. Also, if there has been a break in coverage, You pay the Cost Sharing in effect on the date You receive the Covered Services.

- For items ordered in advance, You pay the Cost Sharing in effect on the order date. Molina will not cover the item unless You still have coverage for it on the date You receive it. You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order. They must receive all of the information they need to fill the prescription before they process the order.

Receiving a Bill

In most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. This payment may cover only portions of the total Cost Sharing for the Covered Services You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due. The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this Policy. However, You are responsible for paying charges for any health care services or treatment, which are not Covered Services under this Policy.

How Your Coverage Satisfies the Affordable Care Act

Your Covered Services include Essential Health Benefits as required by the Affordable Care Act. If non-EHB coverage is included in Your Policy, those Covered Services will be set out in this Policy as well.

Your Essential Health Benefits coverage includes at least the 10 categories of benefits identified in the definition. You cannot be excluded from coverage in any of the 10 EHB categories. However, You will not be eligible for pediatric services that are Covered Services under this Agreement if You are 19 years of age or older. This includes pediatric dental services and pediatric vision services separately obtained through the Health Benefit Exchange.

The Affordable Care Act provides certain rules for Essential Health Benefits. These rules tell Molina how to administer certain benefits and Cost Sharing under this Policy. For example, under the Affordable Care Act, Molina is not allowed to set lifetime limits or annual limits on the dollar value of Essential Health Benefits provided under this Policy. When EHB preventive services are provided by a Participating Provider, You will not have to pay any Cost Sharing amounts. In addition, Molina must ensure that the Cost Sharing which You pay for all Essential Health Benefits does not exceed an Annual Out-of-Pocket Limit that is determined under the Affordable Care Act. For the purposes of this Policy, Cost Sharing refers to any costs that a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable
For qualifying Subscribers, there may be assistance to help make the Policy that You are purchasing under this Agreement more affordable. If You have not done so already, please contact the Health Benefit Exchange to determine if You are eligible for tax credits. Tax credits may reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits. The Health Benefit Exchange also will have information about your Covered Services. The Health Benefit Exchange can assist You in determining whether You are a qualifying Indian who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina will work with the Health Benefit Exchange in helping You.

Molina does not determine or provide Affordable Care Act tax credits.

What is Covered Under My Plan?

This section tells You what medical services Molina covers These are called Your Covered Services.

In order for a service to be covered, it must be Medically Necessary.

You have the right to appeal if a service is denied. These instructions are in the “Grievances and Appeals” section.

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Turn to Experimental or Investigational Services for information. Molina also may cover routine medical costs for Members in Approved Clinical Trials.

Certain medical services described in this section will only be covered by Molina if You obtain Prior Authorization <u>*before*</u> seeking treatment for such services. To read more about Prior Authorization and a complete list of Covered Services that require Prior Authorization, turn to “What is a Prior Authorization?” Prior Authorization does not apply to treatment of Emergency Conditions or for Participating Provider Urgent Care Services.

Outpatient Professional Services

Preventive Care and Services

Preventive Services and the Affordable Care Act

Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services. Please consult with your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for:

- Those evidenced-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
- Those immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) Bright Future guidelines as set forth by the American Academy of Pediatricians; and
- With respect to women, those evidence-informed preventive care, screening, test, and supplies provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

All preventive care must be furnished by a Participating Provider to be covered under this Agreement. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement as they become available to Molina during the product year. Coverage will be as required by the Affordable Care Act.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the Affordable Care Act and applicable Washington law. These coverage limitations also are applicable to the below listed preventive care benefits.

To help You understand and access Your benefits, a non-exhaustive list of preventive services for adults and children that are covered under this policy are listed below.

Preventive Services for Children and Adolescents

The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay Cost Sharing if services are furnished by a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

- Alcohol and drug use assessments for adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Autism screening for children 18-24 months
- Basic vision screening (non- refractive)
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Cervical dysplasia screening: sexually active females
- Complete health history

- Contraceptive services, including emergency contraception and insertion/extraction of contraceptive devices
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Hematocrit or hemoglobin screening
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21. These include those with special health care needs
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Hearing screening
- Health management
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*
- Iron supplementation in children when prescribed by a Participating Provider
- Lead blood level testing (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow up and get the blood test results. Contact Your PCP for additional questions.)
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children 6 years of age and above
- Oral health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 10 to 24)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

*If You take Your child to Your local health department, or the school has given Your child any shot(s), make sure to give a copy of the updated shot record (immunization card) to Your child's PCP.

Preventive Services for Adults and Seniors

The following outpatient preventive care services are covered and recommended for all adults, including seniors. You will not pay any Cost Sharing if You receive services from a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

- Abdominal aortic aneurysm screening: for male former smokers age 65-75
- Alcohol misuse counseling
- Anemia screening: women
- Annual Low-dose Mammograms, including breast tomosynthesis for women age 35 and over which must be performed at designated approved imaging facilities.
- Aspirin for the prevention of preeclampsia
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Bacteriuria screening: pregnant women

- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure screening
- BRCA counseling about breast cancer preventive medication
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies, counseling (includes the purchase of personal-use electric breast pump, one pump per birth. In the event of multiple births, only one pump is covered. This coverage includes the necessary supplies for the pump to operate)
- Cancer screening
- Chlamydial infection screening: women
- Cholesterol check
- Colorectal cancer screening (For persons age 50 and over. May be less than 50 years of age if at high risk or very high risk for colorectal cancer)
- Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment
- Contraceptive services, including emergency contraception, vasectomy, insertion/extraction of contraceptive devices, prescription-based sterilization procedures for women and tubal ligation
- Cytological Screening (pap smear) for women beginning no later than age 18 (also based on Your health status and medical risk)
- Depression screening: adults
- Depression screening: Postpartum women
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diabetes (Type 2) screening for adults with high blood pressure
- Dietary evaluation and nutritional counseling
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Family planning services: These services include all contraceptive drugs, devices and products approved by the Federal Food and Drug Administration
- Fluoride as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Hearing screenings
- Hepatitis B screening: pregnant women
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations
- Medical history and physical exam
- Obesity screening and counseling: offering or referring adults who;
    - have a body mass index (BMI) of 30 kg/m2 or higher, or
    - have additional cardiovascular disease (CVD) risk factors,
    - and includes intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
- Osteoporosis screening for women (based on Your age)

- Prostate specific antigen testing and prostate screening.
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women
- Screening and diagnostic Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 10 to 24)
- Statin preventive medication: adults ages 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions
- Tuberculosis (TB) screening.
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed)

Preventive Care for Adults and Seniors includes a health risk assessment at least once every three years and, for women, an annual well-woman examination.

Physician Services
We cover the following outpatient physician services:

- Prevention, diagnosis, and treatment of illness or injury
- Diabetic eye examinations (dilated retinal examinations)
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye.
  (Benefits are not available for charges connected to routine refractive vision examinations or to the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, "Pediatric Vision.")
- Office visits, including:
  - associated supplies
  - pre- and post-natal visits
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Routine pediatric and adult health exams
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Injections, allergy tests and treatments
- Physician and other Practitioner care in or out of the hospital
- Medically Necessary and without exclusion as defined in title 48 RCW, neurodevelopmental therapy, consisting of physical, occupational, speech therapy, and aural therapy to restore or improve function based on developmental delay and for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service. Any limitation on

Neurodevelopmental services does not apply when the services are received due to a diagnosis of a DSM condition.

- Consultations and well-child care
- If You are a female Member, You may also choose to see an obstetrician/gynecologist (OB/GYN) for routine examinations and prenatal care, and may select an OB/GYN as Your PCP.
- Outpatient maternity care including medically necessary supplies for a home birth; services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia; services of a certified nurse midwife and Other Practitioners; and related laboratory services.
- Medically Necessary at home care
- Routine examinations and prenatal care provided by an OB/GYN to female Members. You may select an OB/GYN as Your PCP. Female Dependents have direct access to obstetrical and gynecological care.
- Diagnosis of infertility (Benefit covers only testing, diagnosis, subject to exclusions in the "Exclusions" section.)
- Osteoporosis services for women (including treatment and appropriate management when such service are determined to be Medically Necessary by the women's PCP, in consultation with Molina)

Habilitative Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 day(s))

Habilitative services and devices are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, aural therapy, durable medical equipment and other services for people with disabilities in a variety of inpatient and/or outpatient settings. These services include services delivered in a school-based health center setting that are not delivered pursuant to any Individual Educational Plan (IEP) under the federal Individuals with Disabilities Education Act of 2004 (IDEA).

Rehabilitative Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 day(s))

We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, aural therapy, speech therapy and occupational therapy (limited to 25 visits for the combined services per calendar year), in a setting appropriate for the level of disability or injury. Services include up to 10 spinal manipulations without referral per calendar year and up to 12 acupuncture services without referral per calendar year. For rehabilitative services, including rehabilitative services received in a Participating Provider's office, You pay the "Rehabilitative Services" Cost Sharing amount stated in the Schedule of Benefits, rather than the Office Visit Cost Sharing amount.

Outpatient Mental/Behavioral Health Services

We cover the following outpatient mental health service when provided by Participating Providers who are physicians or Other Practitioners acting within the scope of their license and qualified to treat mental illness:

- Individual, family and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder (defined below)
- Outpatient services for the purpose of monitoring drug therapy
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations
- Mental health treatment for diagnostic codes F65.0 through F65.4, F65.50 through F65,52, F65.81, F65.89, F65.9 and F66 in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or for "V code" diagnoses including medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria consistent with 42 U.S.C. 18116, Section 1557, RCW 48.30.300 and 49.60.040.

We cover outpatient mental and behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM), including eating disorders associated with a diagnosis of a DSM categorized mental health condition, that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

"**Mental Disorders**" include the following conditions: Severe Mental Illness of a person of any age.

"**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive- compulsive disorder, anorexia nervosa, or bulimia nervosa.

Outpatient Substance Use/Chemical Dependency Services

We cover the following outpatient care for treatment of substance use/chemical dependency:

- Day treatment programs
- Intensive outpatient programs
- Individual, family and group substance use/chemical dependency counseling
- Medical treatment for withdrawal symptoms
- Individual substance use evaluation and treatment
- Group substance use treatment
- We cover substance use/chemical dependency evaluation and treatment
- Group chemical dependency treatment
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations

Unlimited Acupuncture treatment services when provided for chemical dependency.
We do not cover services for alcoholism, drug use, or drug addiction except as otherwise described in this "Outpatient Substance Use/Chemical Dependency Services" section.

Dental and Orthodontic Services

Dental which is 1) emergency in nature; or 2) requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

Dental Services for Radiation Treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer and other neoplastic diseases in Your head or neck. You must receive services from a Participating Provider or a Non-Participating Provider with Prior Authorization. For exceptions please review the information described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

Dental Anesthesia

For dental procedures, We cover general anesthesia and the Participating Provider facility's services associated with the anesthesia. All of the following must be true:

- You are under age 7, or You are physically or developmentally disabled, or Your health is compromised
- The dental procedure must be provided in a hospital or outpatient surgery center because of clinical status or existing medical condition
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other services related to the dental procedure, such as the dentist's services, unless included in this section. For Dental Anesthesia services, Coinsurance Cost Sharing will apply, for either Outpatient Hospital/Facility or Inpatient Hospital/Facility settings.

Dental Services for Injury (trauma)
We cover emergency dental services for injury to natural teeth, including oral surgery due to injury and trauma.

Dental and Orthodontic Services for Cleft Palate
We cover some dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services. They must meet all of the following requirements:

- The services are integral basic part of a reconstructive surgery for cleft palate.
- A Participating Provider provides the services; or
- Molina authorizes a Non-Participating Provider who is a dentist or orthodontist to provide the services.

Services to Treat Temporomandibular Joint Syndrome ("TMJ")
We cover the following services to treat temporomandibular joint syndrome (also known as "TMJ")

- Medically Necessary medical non-surgical treatment (e.g., splint and physical therapy) of TMJ;
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed.

For Covered Services related to dental or orthodontic care in the above sections, You will pay the Cost Sharing You would pay if the services were not related to dental or orthodontic care. For example, see "Inpatient Hospital /Facility Services" in the Molina Healthcare of Washington, Inc. Schedule of Benefits for the Cost Sharing that applies for hospital inpatient care.

Vision Services
We cover the following vision services for all Members:

- Diabetic eye examinations (dilated retinal examinations)
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye

Benefits are not available for charges connected to routine refractive vision examinations or to the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, "Pediatric Vision Services."

Pediatric Vision Services

We cover the following vision services for Members under the age of 19:

- Routine vision screening and comprehensive eye exam which includes dilation as professionally indicated and with refraction every calendar year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months.
- Covered frames include a limited selection of frames. Participating Providers will show the limited selection of frames available to You under this Policy. Frames that are not within the limited selection of frames under this Policy are not covered.
- Prescription lenses: include single vision, lined bifocal, lined trifocal, lenticular lenses and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.
- Prescription contact lenses: limited to one year supply every 12 months, in lieu of prescription lenses and frames; includes evaluation, fitting and follow-up care. Also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of:
    - Aniridia

- o Aniseikonia
- o Anisometropia
- o Aphakia
- o Corneal disorders
- o Irregular astigmatism
- o Keratoconus
- o Pathological myopia
- o Post-traumatic disorders

- Low vision optical devices are covered including low vision services training, and instruction to maximize remaining usable vision. Follow-up care is covered when services are Medically Necessary and Prior Authorization is obtained. With Prior Authorization, coverage includes:
- One comprehensive low vision evaluation every 5 years;
- High-power spectacles, magnifiers, and telescopes as Medically Necessary; and
- Follow-up care – four visits in any five-year period.

Laser corrective surgery is not covered.

Health management and counseling to help You make informed choices

- Health management and counseling to help You understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers, including insertion and extraction all Women's contraceptives methods approved by the Federal Food and Drug Administration.
- Emergency birth control when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Pregnancy testing and counseling
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Screening, testing and counseling of at-risk individuals for HIV

Family Planning services, including all consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer or remove the drugs, devices and other products or services as well as all contraceptive drugs, devices and products approved by the FDA , are provided at No Cost Share to the Member. This includes coverage for a twelve-month refill of contraceptive drugs obtained at one time. You may request a smaller supply or Your prescribing provider may determine that You require a smaller supply. You may receive the contraceptive drugs on-site at a Participating Providers office, if available.

Pregnancy Terminations

Molina covers pregnancy termination services subject to certain coverage restrictions required by the Affordable Care Act and by any applicable laws in the State of Washington.

Pregnancy termination services are office-based procedures and do not require Prior Authorization.

If pregnancy termination services will be provided in an inpatient setting or outpatient hospital Prior Authorization is required.

Office Visit and Outpatient Surgery Cost Sharing will apply.

Keep in mind that some hospitals and Participating Providers may not provide pregnancy termination services.

Nutritional Counseling
We cover Medically Necessary nutritional counseling when necessary to treat medical conditions, and subject to a referral by Your PCP. Nutritional Counseling is limited to 3 visits per lifetime, Cost Sharing will apply.

Phenylketonuria (PKU) and other Inborn Errors of Metabolism
We cover testing and treatment of phenylketonuria (PKU). We also cover other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. The health care professional will consult with a physician who specializes in the treatment of metabolic disease.

The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.

For purposes of this section, the following definitions apply:

"**Formula**" is an enteral product for use at home that is prescribed by a Participating Provider.

"**Special Food Product**" is a food product that is prescribed by a Participating Provider for treatment of PKU. It may also be prescribed for other inborn errors of metabolism. It is used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered. (Prescription Drug Cost Sharing will apply)

Elemental Formula for eosinophilic gastrointestinal associated disorder
We cover Medically Necessary elemental formula, regardless of delivery method, when associated to eosinophilic gastrointestinal associated disorder. This benefit must be order and supervised by a Participating Provider, outpatient professional services cost share applies.

Outpatient Hospital/Facility Services

Chemotherapy and Other Provider-Administered Drugs
We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility Cost Sharing.

Outpatient Surgery
We cover outpatient surgery services and supplies provided by Participating Providers. Services must be provided in an outpatient or ambulatory surgery center or in a hospital operating room. Separate Cost Sharing may apply for professional services and Health Care Facility services.

Outpatient Procedures (other than surgery)
We cover some outpatient procedures other than surgery provided by Participating Providers. A licensed staff member must be required to monitor Your vital signs as You regain sensation after receiving drugs to reduce

sensation or to minimize discomfort. Separate Cost Sharing may apply for professional services and Health Care Facility services for all outpatient procedures.

Radiation Therapy for cancer
We cover Radiation Therapy when furnished by Participating Providers and is Medically Necessary.
Radiation Therapy is subject to Cost Sharing.

Specialized Imaging and Scanning Services
We cover specialized scanning services to include CT Scan, PET Scan and MRI by Participating Providers. Separate Cost Sharing may apply for professional services and facility services. Prior Authorization is required. Molina will help you select an appropriate facility.

Radiology Services (X-Rays)
We cover Medically Necessary x-ray and radiology services, other than specialized scanning services, when furnished by Participating Providers. Separate Cost Sharing may apply for professional services and health care facility services. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

Laboratory Tests and Services
We cover the following services when furnished by Participating Providers and Medically Necessary; These services are subject to Cost Sharing. You must receive these services from Participating Providers, otherwise the services are not covered. You will be 100% responsible for payment to the non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

- Laboratory services, supplies and test, including Medically Necessary genetic testing
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- Blood, blood products, and blood storage, including the services and supplies of a blood bank.
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures
- Alpha-Fetoprotein (AFP) screening

Mental/Behavioral Health
Outpatient Intensive Psychiatric Treatment program

We cover the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility; 24- hour-a-day monitoring must be provided by clinical staff for stabilization of an acute psychiatric crisis; including medication as part of a treatment plan.
- Psychiatric observation for an acute psychiatric crisis
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations

Inpatient Hospital Services

You must have a Prior Authorization to get hospital services except in the case of an Emergency or Participating Provider Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated. Molina will work with You and Your

doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided after stabilization in an out-of-area or Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments to non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of- Pocket Maximum.

Medical/Surgical Services

We cover the following inpatient services in a Participating Provider hospital. These services are generally and customarily provided by acute care general hospitals inside Our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialist physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section)
- Biologicals, fluids and chemotherapy
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections (Molina covers a minimum of 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer)
- Mastectomy-related services, including Covered Services under the "Reconstructive Surgery" section and under the "Prosthetic and Orthotic Devices" section
- Blood, blood products, and their administration
- Physical, occupational, speech therapy, and aural therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning
- Medically necessary services, including surgery due to gender dysphoria.

Chemotherapy and Other Provider-Administered Drugs

We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility Cost Sharing.

Maternity Care

Molina covers medical, surgical and hospital care during the term of pregnancy, which includes coverage for a dependent daughter. This includes prenatal, intrapartum and perinatal care, upon delivery for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

We cover the following maternity care services related to labor and delivery:

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays need to be Authorized by Molina Please refer to "Maternity Care" in the

"Inpatient Hospital Services" section of the Molina Healthcare of Washington, Inc. Summary of Benefits for the Cost Sharing that will apply to these services.

- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is shortened, then at least 3 home care visits will be provided. You and Your physician may agree that 1 or 2 visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory Tests Cost Sharing will apply to laboratory services).
- Nursery services and supplies for newborns, including newly adopted children;
- If You are a medically high-risk pregnant woman about to deliver a baby, We cover transportation, including air transport, to the nearest appropriate Health Care Facility when necessary to protect the life of the infant or mother.
- Prenatal diagnosis of congenital disorders by screening and/or diagnostic procedures if medically necessary.

Mental/Behavioral Health Inpatient Psychiatric Hospitalization

We cover inpatient psychiatric hospitalization in a Participating Provider hospital. Coverage includes room and board, drugs, and services of Participating Provider physicians and other Participating Providers who are licensed health care professionals acting within the scope of their license. Involuntary court-ordered inpatient mental health and behavioral health admissions do not require Prior Authorization. Involuntary court-ordered inpatient mental health and behavioral services beyond 72 hours, will be covered only if deemed Medically Necessary by Molina Healthcare's Medical director or designee and available in a Molina participating hospital under the following conditions. We cover inpatient mental and behavioral health services; including services for treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM), including eating disorders associated with a diagnosis of a DSM categorized mental health condition, that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder".

"**Mental Disorders**" include the following conditions: Severe Mental Illness of a person of any age.

"**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive- compulsive disorder, anorexia nervosa, or bulimia nervosa.

Substance Use/Chemical Dependency

Inpatient Detoxification

We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of withdrawal symptoms. This includes:

- Room and board
- Participating Provider physician services
- Medication
- Dependency recovery services, education, and counseling.

We cover for substance use/chemical dependency under this policy.

Residential Recovery Services
We cover substance use treatment in a nonmedical transitional residential recovery setting approved in writing by Molina Healthcare. These settings provide counseling and support services in a structured environment.

Skilled Nursing Facility (60 days per calendar year)
We cover skilled nursing facility (SNF) services when Medically Necessary and referred by Your PCP. Covered SNF services include:

- Room and board
- Physician, nursing and Other Practitioner services, including licensed behavioral health providers
- Medications
- Injections

You must have Prior Authorization for these services before the service begins. You will continue to get care without interruption.

The SNF benefit is limited to 60 days per calendar year.

Long-term Care Facility following hospitalization
We cover up to 60 days of Medically Necessary care at a Long-Term Care Facility following hospitalization if You resided in that Long-Term Care Facility immediately prior to the hospitalization, and all of the following are met:

- Your Primary Care Physician determines that Your medical care needs can be met at the requested Facility. The requested Facility has all applicable licenses and certifications, and is not under a stop placement order that prevents Your readmission.

- The requested Facility agrees to accept payment for Covered Services at the rate We pay to similar Facilities that are Participating Providers

- The requested Facility agrees to abide by the standards, terms, and conditions We require for similar Facilities that are Participating Providers for (i) utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting

A "Long-Term Care Facility" or "Facility" for the purpose of this benefit is a nursing facility licensed under Chapter 18.51 of the Revised Code of Washington, a continuing care retirement community defined under Section 70.38.025 of the Revised Code of Washington, or an assisted living facility licensed under Chapter 18.20 of the Revised Code of Washington.

You, or Your authorized representative, must obtain Prior Authorization for these services. Inpatient Hospital/Facility Services Coinsurance cost share will apply.

Hospice Care
If You are terminally ill, We cover these hospice services:

- Home hospice services
- A semi-private room in a hospice facility
- Nursing care
- Medical social services
- Home health aide and homemaker services for outpatient care
- Physician services
- Drugs

- Medical supplies and appliances
- Respite care for up to fourteen (14) days per lifetime. Respite is short-term inpatient care provided in order to give relief to a person caring for You
- Counseling services for You and Your family
- Development of a care plan for You
- Short term inpatient care
- Pain control
- Symptom management
- Physical therapy, occupational therapy, and speech-language therapy. We provide these therapies for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

The hospice benefit is for people who are diagnosed with a terminal illness. Terminal illness means a life expectancy of 12 months or less. They can choose hospice care instead of the traditional services covered by this Policy. You may contact Molina for further information. Please notify Molina before services are rendered by calling 1 (888) 858-3492. If You are deaf or hard of hearing, You may call Our dedicated TTY for the deaf or hard of hearing toll-free at (800) 735-2989.

Alternative to Hospitalization or Inpatient care

To the extent mandated by Washington State law, home health care furnished by duly licensed home health, hospice and home care agencies covered by this Policy may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home health care:

- can be provided at equal or lesser cost;
- is the most appropriate and cost-effective setting; and
- is substituted with the consent of the Insured and upon the recommendation of the Insured's attending Physician or licensed health care Provider that such care will adequately meet the Insured's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the individual Insured. We may require a written treatment plan that has been approved by the Insured's attending Physician or licensed health care Provider. Coverage of substituted home health care is limited to the Maximum Benefits available for Hospital or other inpatient care under this Policy, and is subject to any applicable Deductible, Coinsurance and Policy limits.

Approved Clinical Trials

We cover routine patient care costs for qualifying Members. Routine patient care costs means items and services delivered to the Member that are consistent with, and typically covered by Molina, for coverage for a Member who is not enrolled in a clinical trial. Qualifying Members are those participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You need to be enrolled in this Policy. Be diagnosed with cancer or other life threatening disease or condition. You must either:

- Be accepted into an approved clinical trial (as defined below) or
- Be referred by a Molina doctor who is a Participating Provider

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial. These trials are conducted in relation to the prevention, detection, or treatment of cancer. They may also be conducted for other life-threatening disease or condition. In addition:

- The study is approved or funded by one or more of the following: the National Institutes of Health, the

Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy; or

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- All approvals and authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. Contact Molina or Your PCP for further information.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Your routine patient costs. Such costs are associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this Policy based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered. They will not be covered if the approved clinical trial is for the investigation of that drug. They will also not be covered for medication that is typically provided free of charge to Members in the clinical trial.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service was not specifically related to an approved clinical trial. In other words, You will pay the Cost Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Washington, Inc. Schedule of Benefits.

Molina does not have an obligation to cover certain items and services that are not routine patient costs, as determined by the Affordable Care Act, even when You incur these costs while in an approved clinical trial. Costs excluded from coverage under Your Policy include:

- The investigational item, device or service itself,
- Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and
- Any service that does not fit the established standard of care for the patient's diagnosis.

Reconstructive Surgery

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body. These abnormal structures may be caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. If a Participating Provider physician decides that it is necessary to improve function, or create a normal appearance, to the extent possible, the services will be covered.
- Following Medically Necessary removal of all or part of a breast, Molina covers reconstruction of the breast. Molina will also cover surgery and reconstruction of the other breast to produce a symmetrical appearance. Molina covers treatment of physical complications, including lymphedemas.

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services were not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Washington, Inc. Schedule of Benefits.

Reconstructive surgery exclusions

The following reconstructive surgery services are **not** covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance.
- Surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Transplant Services

We cover transplants of organs, tissue, or bone marrow or artificial organ transplants based on Molina's medical guidelines and manufacturer's recommendations at participating facilities. Molina must authorize services for care to a transplant facility, as described in the "Prior Authorization" section, under "What is a Prior Authorization?".

After the authorization to a transplant facility, the following applies:

- If either the physician or the authorized Health Care Facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that decision is made.
- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor. Molina will provide services for an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You. This may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at 1 (888) 858-3492.
- When medically appropriate, transplant services, supplies and treatment covered under this Policy will also be covered when provided in an outpatient setting.

For covered transplant services, You will pay the Cost Sharing You would pay if the Covered Services were not related to transplant services. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Washington, Inc. Schedule of Benefit. Limited transplant-related travel services will be covered subject to Prior Authorization. Guidelines for transplant-related travel services are available by calling Our Customer Support Center toll-free at 1 (888) 858-3492.

Molina provides or pays for donation-related services for actual or potential donors (whether or not they are Members) in accord with Our guidelines for donor services at no charge.

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications when:

- They are ordered by a Participating Provider treating You and the prescription drug is listed in the Molina Drug Formulary or has been approved by Molina's Pharmacy Department. Teaching doses of self-administered injections are limited to 3 doses per medication per lifetime.
- They are ordered or given while You are in an emergency room or hospital.
- They are given while You are in a skilled nursing facility and are ordered by a Participating Provider in connection with a Covered Service. The prescription drug or medication must be filled through a pharmacy that is in the Molina pharmacy network.
- The prescription drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

We cover prescription drugs and medications at a plan contracted retail pharmacy unless a prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education that cannot be provided by a retail pharmacy.

Please note, Cost Sharing for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third party Cost-Sharing assistance, will not apply toward any Deductible, or the Annual Out-of-Pocket Maximum under Your Plan.

We cover:

- Tier-1: Lower-Cost Generic and Brand Name Drugs,
- Tier-2: Preferred Generic and Brand Name Drugs,
- Tier-3: Non-Preferred Brand Name Drugs,
- Tier-4: Generic and Brand Name Specialty Drugs, and
- Tier-5: Preventive Drugs.

We cover drugs when they are on the Drug Formulary. We cover drugs when obtained through Molina's Participating Provider pharmacies within the Service Area. Non-formulary drugs may be covered only as provided in the "Access to Drugs Which Are Not Covered" section below.

Prescription drugs are covered outside the Service Area for Emergency Services only.

If You have trouble getting a prescription filled at the pharmacy, please call Our Customer Support Center toll-free at 1 (888) 560-4087 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629 or contact Us with the Telecommunications Relay Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 560-4087. You may view a list of pharmacies on Molina Healthcare's website MolinaMarketplace.com.

Molina Healthcare Drug Formulary (List of Drugs)

Molina Healthcare has a list of drugs that We will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community.

The group meets every 3 months to talk about the drugs that are in the Drug Formulary. They review new drugs and changes in health care, in order to find the most effective drugs for different conditions. Drugs are added to or removed from the Drug Formulary based on changes in medical practice and medical technology. They may also be added to the Drug Formulary when new drugs come on the market.

Formulary generic drugs are those drugs listed in the Molina Drug Formulary that have the same ingredients as brand name drugs. To be FDA (government) approved, a generic drug must have the same active ingredient, strength, and dosage (formulation) as the brand name drug. Companies making a generic drug have to prove to the FDA that the drug works just as well and is as safe as the brand name drug.

Formulary brand name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina and Our pharmacy benefit manager.

You can look at Our Drug Formulary on Our Molina Healthcare website at MolinaMarketplace.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 560-4087, Monday through Friday, 8:00 a.m.

through 5:00 p.m. ET. If You are deaf or hard of hearing, call toll-free 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

You can also ask Us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Step Therapy and Considerations for Drugs that require a Prior Authorization
Our Pharmacy Director and/or Our Medical Director will review general medical criteria and will work in conjunction with Your prescribing provider. The following parameters may be considered when reviewing Your request:

- Diagnosis and relevant concurrent medical conditions,
- Age and sex,
- Allergies,
- Clinical rationale for selecting the drug,
- If Your condition being treated is consistent with FDA approved indications and/or meets approved criteria for safe use,
- Expected outcome of therapy and methods to be used to measure outcome,
- Anticipated duration of therapy,
- Previous experience with this drug, if any,
- Previous drug therapy, drug responses and adverse effects,
- Concurrent drug therapy,
- Compliance history,
- Prescriber's familiarity with the drug,
- Cost effectiveness of the drug on overall healthcare costs, and
- Whether or not You have tried and failed an adequate supply of formulary drugs.

Off-Label Drug Use Statement
Molina will cover off-label use of a drug to treat You for a covered, chronic, disabling, or life-threatening illness if the drug (1) has been approved by the FDA for at least one indication, and (2) is recognized as an effective drug for treatment of the indication in any standard drug reference compendium or any substantially accepted peer-reviewed medical literature. Off-label drug use must be Medically Necessary to treat Your covered condition, and must be Prior Authorized. We will not deny coverage of off-label drug use solely on the basis that the drug is not on the Drug Formulary.

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed on the Schedule of Benefits. Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, is not subject to Cost Sharing.

Prescription Drug Synchronization
Molina provides for prescription drug synchronization, specific to the applicable laws within the state of Washington. Prescription drug synchronization is applicable to drugs listed in the Molina Healthcare Drug Formulary and any Prior Authorized non-formulary drugs.

You may request a Participating Provider to provide synchronization of a prescription drug with other medications you may be taking. Upon the Participating Provider's determination that filling or refilling a prescription drug is in Your best interest, taking into account the appropriateness of synchronization for the drug being dispensed, Molina will provide the drug at less than the standard 30-day supply. Prescription drug synchronization requests which are less than a 30-day supply, determined by Participating Providers not to pose a threat to Your safety and not suspected of fraud or abuse will be dispensed as a 15-day supply.

You will be charged the prescription drug Cost-Share equal to 50% of the prescription drug Cost-Share listed in Your Molina Healthcare of Washington Schedule of Benefits.

In addition, Molina's pharmacy procedures will allow you, without consulting a physician, prescription or refill from a physician, to provide for one early refill of a prescription for topical ophthalmic products if all of the following criteria are met:

(1) The refill is requested by a patient at or after seventy percent of the predicted days of use of:

(a) The date the original prescription was dispensed to the patient; or

(b) The date that the last refill of the prescription was dispensed to the patient;

(2) The prescriber indicates on the original prescription that a specific number of refills will be needed; and

(3) The refill does not exceed the number of refills that the prescriber indicated under subsection (2) of this section.

Tier-1: Lower-Cost Generic and Brand Name Drugs

Formulary drugs in this tier include lower-cost generic and brand name drugs. Specialty drugs are not included in this tier.

Lower-cost generic and brand name drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as "Tier-1" in the Molina Drug Formulary.

Tier-2 Preferred Generic and Brand Name Drugs

Formulary drugs in this tier include preferred generic and brand name drugs. Specialty drugs are not included in this tier.

Preferred generic and brand name drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as "Tier-2" in the Molina Drug Formulary. .

Tier-3 Non-Preferred Brand Name Drugs

Formulary drugs in this tier include non-preferred brand name drugs. Specialty drugs are not included in this tier. Non-preferred brand name drugs are those drugs listed in the Molina Drug Formulary that are designated as "Tier-3" due to lesser clinical effectiveness and cost differences. Generally, there are preferred and often less costly therapeutic alternatives at a lower tier.

Tier-4 Generic and Brand Name Specialty Drugs

Formulary drugs in this tier include both generic and brand name specialty drugs, including biosimilars.

Specialty drugs are prescription legend drugs within the Molina Healthcare Drug Formulary that:

- Are only approved to treat limited patient populations, indications or conditions, including but not limited to growth hormone injections and drugs for treatment of infertility; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies; or
- A biosimilar, a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

Molina may require that Specialty drugs be obtained from a Participating Provider specialty pharmacy or facility for coverage. Our specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office.

We cover orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications. The maximum Cost Share for an orally administered anti-cancer medication is for up to a 30 day supply and is not subject to a Deductible.

Tier-5 Preventive Drugs

Formulary Preventive drugs are drugs listed in the Molina Drug Formulary that are considered to be used for preventive purposes, including all contraceptive drugs, devices and products , including prescription-based sterilization procedures approved by the FDA, or if they are being prescribed primarily (1) to prevent the symptomatic onset of a condition in a person who has developed risk factors for a disease that has not yet become clinically apparent or (2) to prevent recurrence of a disease or condition from which the patient has recovered. A drug is not considered preventive if it is being prescribed to treat an existing, symptomatic illness, injury, or condition. Formulary Preventative drugs may include Generic or Brand Name drugs.

Access to Drugs That Are Not Covered

Molina has a process to allow You to request and gain access to clinically appropriate drugs that are not covered under Your product.

Molina Healthcare may cover specific non-formulary drugs when the prescriber documents in Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

If Your doctor prescribes a drug that is not listed on the Drug Formulary, Your doctor must submit a Prior Authorization request to Molina Healthcare's Pharmacy department.

- If You do not obtain a Prior Authorization from Molina, We will send a letter to You and Your doctor stating why the drug was denied. You may purchase the drug at the full cost charged by the pharmacy.
- If You obtain a Prior Authorization from Molina, We will contact Your doctor. You may purchase the drug at the Cost Sharing for Tier-3 for non-specialty drugs or Tier-4 for specialty drugs.

For substitution of a Formulary Generic Drug with a Non-Formulary Brand Drug, You may purchase the brand name drug at the following Cost Sharing:

- The Cost Sharing for Tier-3 for non-specialty drugs or Tier-4 for specialty drugs, plus
- The difference in cost between the formulary generic drug and brand name drug.

If You are taking a drug that is no longer on Our Drug Formulary, Your doctor can ask Us to keep covering it by sending Us a Prior Authorization request for the drug.

The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You.

There are two types of requests for clinically appropriate drugs that are not covered under Your product:

- Expedited Exception Request for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.

- Standard Exception Request.

You and/or Your Participating Provider will be notified of Our decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

If initial request is denied, You and/or Your Participating Provider may request an IRO review. You and/or Your Participating Provider will be notified of the IRO's decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

Prior Authorization Process

You may call Molina Healthcare at 1 (888) 858-3492 to request Prior Authorization for prescription drugs. An urgent care review of a prescription drug Prior Authorization can be requested for care or treatment where passage of time could seriously jeopardize your health. Molina will make a determination on a prescription drug urgent care review request within 48 hours of receipt of the request and all necessary information. For non-urgent prescription drug review requests, the Prior Authorization requests will be processed within five calendar days from Molina's receipt of the request and all necessary information.

If additional information is needed to make the prescription drug Prior Authorization determination, Molina will approve or deny the request within 48 hours of the receipt of the additional information for a prescription drug urgent care review request or four calendar days for a non-urgent review request. We will deny a Prior Authorization if information We request is not provided to us.

If a prescription drug request is not Medically Necessary, it may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are in the section "Grievances and Appeals".

We can explain to You how Prior Authorization decisions are made. We will send You a copy of the approval process if You request it.

Over-the-Counter Preventive Drugs and Supplements

Over-the-counter drugs and supplements that are required by state and federal laws to be covered for preventive care are available at no charge when prescribed by a Participating Provider.

- Over-the-counter contraceptive drugs, devices and products approved by the FDA do not require a prescription.
- Folic Acid for women planning or capable of pregnancy
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Iron Supplements for children age 6 to 12 months at increased risk for iron deficiency anemia
- Aspirin for adults for prevention of cardiovascular disease

Stop-Smoking Drugs

We cover drugs to help You stop smoking. You will have no Cost Sharing for stop smoking drugs. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a 3-month supply of stop-smoking medication.

Mail Order Availability of Formulary Prescription Drugs

Molina offers You a mail order Formulary Prescription drug option. Formulary Prescription drugs can be mailed to You within 10 days from order request and approval. Cost Sharing is a 90-day supply applied at two times Your appropriate Copayment or Coinsurance Cost Share based on Your drug tier for one month.

You may request mail order service in the following ways:

- You can order online. Visit MolinaMarketplace.com and select the mail order option. Then follow the prompts.
- You can call the FastStart® toll-free number at 1 (800) 875-0867. Provide Your Molina Marketplace Member number (found on Your ID card), Your prescription name(s), Your doctor's name and phone number, and Your mailing address.
- You can mail a mail-order request form. Visit MolinaMarketplace.com and select the mail order form option. Complete and mail the form to the address on the form along with Your payment. You can give Your doctor's office the toll-free FastStart® physician number 1 (800) 378-5697 and ask Your doctor to call, fax, or electronically prescribe Your prescription. To speed up the process, Your doctor will need Your Molina Marketplace Member number (found on Your ID card), Your date of birth, and Your mailing address.

Cancer Drug Therapy

As required by state law, drugs for cancer therapy and reasonable costs for administering them are covered. These drugs are covered regardless of whether the federal FDA has approved the cancer drug to be used for the type of tumor for which the drugs are being used.

Orally Administered Anti-Cancer Medications
We cover prescribed, self-administered, anti-cancer medications that are used to kill or slow the growth of cancerous cells on a comparable basis to Our coverage for cancer medications that are administered by a health care provider or in a facility.

Diabetic Supplies

Diabetic supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, blood glucose test strips and urine test strips are covered supplies. Select pen delivery systems for the administration of insulin are also covered.

Day Supply Limit

The prescribing Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of an item that constitutes a Medically Necessary 30-day supply for You. Upon payment of the Cost Sharing specified in this "Prescription Drug Coverage" section, You will receive the supply prescribed up to a 30-day supply in a 30-day period. Quantities that exceed the day supply limit are not covered unless Prior Authorization is obtained.

Emergency Fill

Emergency Fill is a short term dispensed amount of medication that allows time for the processing of a Prior-Authorization request. Only the Emergency Fill dosage of the medication will be approved and paid.

Emergency Fills may be appropriate in circumstances where You present at an in-network-pharmacy with an 'urgent therapeutic need' for a prescribed medication that requires a prior-authorization due to formulary or other utilization management restrictions. An in-network-pharmacy may do a one-time override to provide You with an Emergency Fill without a Prior Authorization if;

- In-network-pharmacy cannot reach the Molina's prior authorization department by phone because it is outside of Our business hours;
- Molina is available to respond by phone to the dispensing pharmacy regarding benefit but We cannot reach Your prescribing provider for full consultation;
- You have an urgent therapeutic need; where a passage of time (i.e., the timeframe required for an Urgent Review) without treatment would result in imminent emergency care, hospital admission OR might seriously jeopardize the life or health of You or others in contact with You.

The dosage of the Emergency Fill must either be the minimum packaging size that cannot be broken (e.g., injectable), or the lesser of a 7-day supply or the amount as prescribed. In the event the medication is to be continued for treatment beyond the Emergency Fill authorization, Molina may apply formulary or utilization management restrictions that will be reviewed following the Our standard procedure.

The medication list for Emergency Fill to address urgent therapeutic needs is as follows:

- Antibiotics & Antivirals for acute infections
- Medications for mental health conditions
- Anticoagulant/Antiplatelet medication
- Antiemetics (for imminent nausea and vomiting)
- Anti-Rejection/Immunosuppression medication for post-transplant patients
- Antiretrovirals (continuing current therapy, not new starts except for emergency use)
- Cardiovascular medications for acute treatment only (for example, antiarrhythmics, anti-hypertensives)
- Epinephrine injections
- Generically available, immediate release pain medication (does not include transmucosal immediate release fentanyl)
- Gout flare (acute) medications
- Insulin (continuing current therapy, not new starts)
- Naloxone
- Non-OTC pediculocides-lice and scabies treatments
- Rescue Inhalants and delivery support devices
- Seizure/epilepsy medications
- Triptans

You will be responsible for a 30 day supply cost share. The cost share is based on the tier in which Molina has placed the drug. This may also include Deductibles, Coinsurance, Copayments and similar charges. For cost share information please refer to the Schedule of Benefits in this Agreement.

Please be aware that Specialty Drugs for chronic conditions, such as oncology, hepatitis C, biologics, multiple sclerosis treatments, and enzyme replacements and all drug listed on Tier 4 are not meet urgent therapeutic need and are not covered for Emergency Fill. Emergency fills are also not covered at the following;

- Out of Network/Non-Contracted pharmacy

- Refill too soon
- Quantity limitation exceeded

YOUR PRESCRIPTION DRUG RIGHTS
You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, please contact Us at 1-(888) 858-3492 or visit MolinaMarketplace.com. We are here Monday through Friday, 7:30 a.m. through 6:30 p.m. PT. If You are deaf or hard of hearing, You may call Our dedicated TTY for the deaf or hard of hearing toll-free at (800) 735-2989.

If You would like to know more about Your rights, or if You have concerns about Your plan, You may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If You have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov

ANCILLARY SERVICES

Durable Medical Equipment

If You need Durable Medical Equipment, Molina Healthcare will rent or purchase the equipment for You. Prior Authorization (approval) from Molina Healthcare is required for Durable Medical Equipment. The Durable Medical Equipment must be provided through a vendor that is contracted with Molina Healthcare. When Prior Authorized, Durable Medical Equipment will be covered for use on either an inpatient or outpatient basis. We cover reasonable sales tax, repairs, maintenance, delivery, and related supplies for Durable Medical Equipment. You may be responsible for repairs to Durable Medical Equipment if they are due to misuse or loss. Covered Durable Medical Equipment includes (but is not limited to):

- Oxygen and oxygen equipment
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Colostomy supplies (limited to pouches, face plates, belts, irrigation catheters, and skin barriers)
- Mobility Enhancing Equipment

In addition, We cover the following Durable Medical Equipment and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Podiatric devices to prevent or treat diabetes related foot problems
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but We do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets Your medical needs
- You receive the device from the provider or vendor that Molina Healthcare selects

When We do cover a prosthetic and orthotic device including but not limited to testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a prosthetic or orthotic device. If We cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, Osseo integrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by Molina Healthcare. For internally implanted devices, please refer to the "Inpatient Hospital Services" or "Outpatient Hospital/Facility Services" sections (as applicable) of the Molina Healthcare of Washington, Inc. Schedule of Benefits to see the Cost Sharing applicable to these devices. Implants pertaining to sexual dysfunction as a primary diagnosis are not included in this benefit.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months when required to hold a prosthesis.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Splints
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Prostheses used to replace a missing part (such as a hand, arm, or leg) that is needed to alleviate or correct illness, injury, or congenital defects, including braces (not orthodontic braces), limited to medically appropriate equipment and subject to Prior Authorization. Repair or replacement of such prostheses is a Covered Service only when Medically Necessary and subject to Prior Authorization.

For external devices, Durable Medical Equipment Cost Sharing will apply.

Home Health Care (up to 130 visits per year)

We cover these home health care services – i.e., health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness – when such services are Medically Necessary, referred by Your PCP, and approved by Molina Healthcare:

- Part-time skilled nursing services
- Nurse visits
- In-home medical care services
- Physical therapy, occupational therapy, or speech therapy
- Medical social services
- Home health aide services
- Medical supplies
- Necessary medical appliances

The following home health care services are covered under Your Policy:

- Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four hours per visit by a home health aide
- Up to 130 visits per calendar year (counting all home health visits)

You must receive a Prior Authorization for home health services after seven (7) visits. Please refer to the "Exclusions" section of this Policy for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation

We cover Emergency transportation (ground and air ambulance), or ambulance transport services provided through the "911" emergency response system. These services are covered only when any other type of transport would put your health or safety at risk. Covered emergency medical transportation services will be provided at the cost share identified within the Schedule of Benefits, up to the lesser of Molina's Allowed Amount for such services. Please note: You may be responsible for provider charges that exceed Molina's Allowed Amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.

Non-Emergency Medical Transportation

We cover non-routine, non-emergency Medically Necessary transportation, such as van or ambulance transportation between hospitals. Prior Authorization may be required. Covered non-emergency medical transportation services will be provided at the cost share identified within the Schedule of Benefits for inpatient hospital services.

OTHER SERVICES

Dialysis Services

We cover acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside Our Service Area
- You or a Participating Provider notifies Molina before services are provided. (Prior Authorization is not required)

These services are covered inpatient, outpatient and inside the home.

Hearing Services

We do not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section).

We do cover routine hearing screenings that are Preventive Care Services at no charge.

EXCLUSIONS

What is Excluded from Coverage Under My Plan?

This "Exclusions" section lists specific items and services excluded from coverage under this Policy. These exclusions apply to all services that would otherwise be covered under this Policy regardless of whether the services

are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Artificial Insemination and Conception by Artificial Means
All services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Bariatric Surgery
Bariatric surgery is not covered.

Certain Exams and Services
Physical exams and other services 1) required for obtaining or maintaining employment or participation in employee programs, 2) required for insurance or licensing, or 3) on court order or required for parole or probation. This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary.

Cosmetic Services
Services that are intended primarily to change or maintain Your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "What is Covered Under My Plan?" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part
- Medically necessary surgery due to gender dysphoria

Custodial Care
Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

Dental and Orthodontic Services
Dental services following treatment for injury to sound natural teeth. However, services or appliances necessary for or resulting from medical treatment are covered if the service is: 1) emergency in nature; or 2) requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

Dietician
A service of a dietician is not a covered benefit. This exclusion does not apply to services under "Hospice Care" or for Covered Services described in the section titled, "Phenylketonuria (PKU) and Other Inborn Errors of Metabolism".

Disposable Supplies
Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, under pads, and other incontinence supplies.

This exclusion does not apply to disposable supplies that are listed as covered in the “What is Covered Under My Plan?” section.

Erectile Dysfunction Drugs
Erectile dysfunction drugs are not covered unless required by state law.

Experimental or Investigational Services
Any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in the medical community in the State of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

This exclusion does not apply to any of the following:

- Services covered under “Approved Clinical Trials” in the “What is Covered Under My Plan?”section

Please refer to the “External Review or Appeal” section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Gene Therapy
Molina does not cover gene therapy.

Hair Loss or Growth Treatment
We do not cover items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Infertility Services
Services related to infertility treatment and reversal of voluntary sterilization are not covered. This exclusion does not apply to Covered Services for the diagnosis of infertility.

Intermediate Care
Care in a licensed intermediate care facility. This exclusion does not apply to services covered under “Durable Medical Equipment”, “Home Health Care”, and “Hospice Care” in the “What is Covered Under My Plan?” section.

Intermediate Care facility (ICF)
A health related facility designed to provide custodial care for individuals unable to care for themselves because of mental or physical infirmity, but without the degree of care provided by a hospital or skilled nursing facility.

Items and Services That are Not Health Care Items and Services
Molina Healthcare does not cover services that are not health care services. Examples of these types of services are:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching You how to read, whether or not You have dyslexia

- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy

Items and Services to Correct Refractive Defects of the Eye
Molina does not cover items and services (such as eye surgery or contact lenses to reshape the eye) for correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section.

Male Contraceptives
Condoms are not covered

Oral Nutrition
Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Formulas and special food products when prescribed for the treatment of Phenylketonuria or other inborn errors of metabolism involving amino acids, in accordance with the "Phenylketonuria (PKU)" section of this Policy
- Elemental Formula for eosinophilic gastrointestinal associated disorder

Private Duty Nursing Services
We do not cover private duty nursing services.

Residential Care
Care in a facility where You stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery services covered under the "Substance Use Disorder Services" section.

Routine Foot Care Items and Services
Routine foot care items and services which are not Medically Necessary (for example, Medically Necessary for the treatment of diabetes)

Services Not Approved by the Federal Food and Drug Administration
Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan" section.

Please refer to the "External Review or Appeal" for Denials of Experimental/Investigational Therapies section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People
We do not cover services performed by people who do not require licenses or certificates by the state to provide health care services, except as otherwise provided in this Policy.

Services Related to a Non-Covered Service
When a Service is not covered, all services related to the non-Covered Service are excluded; except for services, Molina would otherwise cover to treat complications of the non-Covered Service. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service. For example, if You have a non-covered bariatric or cosmetic surgery, Molina would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina would cover any services that Molina would otherwise cover to treat that complication.

Sexual Dysfunction
Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications are not covered unless required by state law.

Surrogacy
Services for anyone in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel and Lodging Expenses
Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina's travel and lodging guidelines. Molina Healthcare's travel and lodging guidelines are available from Our Customer Support Center by calling toll free at 1 (888) 858-3492. You may call Our dedicated TTY for the deaf or hard of hearing toll-free at (800) 735-2989. You may dial 711 for the Telecommunications Service.

Services Provided Outside the United States (or Service Area)

Any services and supplies provided to a Member outside the United States if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, Specialist Physician care, and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area unless they are Emergency Services furnished to a Member while traveling. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered.

Third-party liability

You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, if You are made whole for all other damages resulting from the wrongful act or omission before Molina Healthcare is entitled to reimbursement, then You shall:

- Reimburse Molina Healthcare for the reasonable cost of services paid by Molina Healthcare to the extent permitted by Washington law immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and

- Fully cooperate with Molina Healthcare's effectuation of its lien rights for the reasonable value of services provided by Molina Healthcare to the extent permitted under Washington law. Molina Healthcare's lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

Molina Healthcare shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and You shall cooperate to fully and completely assist in protecting the rights of Molina Healthcare including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina Healthcare shall not furnish benefits under this Agreement that duplicate the benefits to which You are entitled under any applicable workers' compensation law. You are responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under the workers compensation system can be reasonably expected. Failure to take proper and timely action will preclude Molina Healthcare's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between You and the Workers' Compensation carrier, as to Your ability to collect under workers' compensation laws, Molina Healthcare will provide the benefits described in this Agreement until resolution of the dispute.

If Molina Healthcare provides benefits which duplicate the benefits You are entitled to under workers' compensation law, Molina Healthcare shall be entitled to reimbursement for the reasonable cost of such benefits.

RENEWAL AND TERMINATION

How Does my Molina Healthcare Coverage Renew?

Coverage shall be renewed on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. Renewal is subject to Molina Healthcare's right to amend this Policy. You must follow the procedures required by the Health Benefit Exchange to redetermine Your eligibility for enrollment every year during the Health Benefit Exchange's annual open enrollment period.

Changes in Premiums, Deductibles, Copayments and Covered Services:

Any change to this Agreement, including, but not limited to, changes in Premiums, or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina. The Marketplace determines your eligibility and advance premium tax credit.

When Will My Molina Membership End?

(Termination of Covered Services)

The termination date of Your coverage is the first day You are not covered with Molina (for example, if Your termination date is July 1, 2018, Your last minute of coverage was at 11:59 p.m. on June 30, 2018). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or deception in the use of services or facilities, Molina will return to You within 30 days the amount of Premiums paid to Molina which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due Molina.

Your membership with Molina will terminate if You:

- **No Longer Meet Eligibility Requirements:** You no longer meet the age or other eligibility requirements for coverage under this Policy as required by Molina or the Health Benefit Exchange. You no longer live Molina's Service Area for this Policy. The Health Benefit Exchange will send You notice of any eligibility determination. Molina will send You notice when it learns You have moved out of the Service Area.
- **For Non-Age-Related loss of Eligibility,** Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.
- **For a Dependent Child Reaching the Limiting Age of 26**, Coverage under this Policy, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the month in which the Dependent Child reaches the limiting age of 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)".
- **For a Non-Dependent Member with Child-Only Coverage Reaching the Limiting Age**, Child-Only Coverage under this Policy, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the month in which the non- Dependent Member reaches the limiting age of 21. When Child-Only Coverage under this Policy terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Health Benefit Exchange.
- **Request Disenrollment:** You decide to end Your membership and disenroll from Molina by notifying Health Benefit Exchange. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. Molina may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.
- **Have Child-Only Coverage**: Child-Only Coverage under this Policy, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches age 21. When Child-Only Coverage under this Policy terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Health Benefit Exchange.
- **Change Health Benefit Exchange Health Plans**: You decide to change from Molina to another health plan offered through the Health Benefit Exchange during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Health Benefit Exchange's special enrollment procedures, or when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.
- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina. In which case a notice of termination will be sent. and Your membership will end at 11:59 p.m. on the seventh day from the date the notice of termination is mailed. Some examples include:

    - Misrepresenting eligibility information.
    - Presenting an invalid prescription or physician order.
    - Misusing a Molina Healthcare Member ID Card (or letting someone else use it).

After Your first 24 months of coverage, Molina may not terminate Your coverage due to any intentional omissions, misrepresentations or inaccuracies in Your application form.

If Molina Healthcare terminates Your membership for cause, You may not be allowed to enroll with Us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

- **Discontinuation:** If Molina ceases to provide or arrange for the provision of health benefits for new or existing health care service plan policies, in which case Molina will provide You with written notice at least 90 days prior to discontinuation of those policies.
- **Withdrawal of Plan:** Molina withdraws this Policy from the market, in which case Molina will provide You with written notice at least 180 days before the termination date.
- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina may terminate Your coverage as further described below.

Your coverage under certain Covered Services will terminate if Your eligibility for such benefits end. If only certain Covered Services end because a Member attains a certain age, then coverage of those benefits under this Policy will end at 11:59 p.m. on the last day of the month in which the Member has reached the limiting age, without affecting that Member's coverage under the remainder of this Policy. Any Dependent Member, who no longer is eligible to remain on the coverage because of termination of marriage or death of the principle Subscriber, shall have the right to continue this Policy without any proof of insurability. Please contact the Molina Customer Support Center at 1 (888) 858- 3492 or dial 711 for the National Relay Service for the deaf or hard of hearing for assistance in transferring Your coverage.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums

Your Premium payment obligations are as follows:

- Your Premium payment for the upcoming coverage month is due no later than the 25th day of that month. This is the "**Due Date".** Molina Healthcare will send You a bill in advance of the Due Date for the upcoming coverage month. If Molina Healthcare does not receive the full Premium payment due on or before the Due Date, Molina Healthcare will send a notice of non- receipt of Premium payment and cancellation of coverage (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:
- A statement that Molina Healthcare has not received full Premium payment and that We will terminate this Agreement for nonpayment if We do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
- The amount of Premiums due.
- The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if We do not receive the required Premiums.

If You have received a Late Notice that Your coverage is being terminated or not renewed due to failure to pay Your Premium, Molina Healthcare will give a:

- 30-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit. Molina will process payment for Covered Services received during the grace period. You will be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period; or
- Three month grace period to pay the full Premium payment due if You receive advance payment of the premium tax credit. Molina will hold payment for Covered Services received after the first month of the grace period until We receive the delinquent Premiums. If Premiums are not received by the end of the three-month grace period, You will be responsible for payment of the Covered Services received during the second and third months. In addition, You will still be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period if You receive advance payment of the Premium tax credit.

During the grace period applicable to You, You can avoid termination or nonrenewal of this Agreement by paying the full Premium payment You owe to Molina Healthcare. If You do not pay the full Premium payment by the end of the grace period, this Agreement will be terminated.

Termination or nonrenewal of this Agreement for non-payment will be effective as of 11:59 p.m.:

- The last day of the month prior to the beginning of the grace period if You do not receive advance payment of the premium tax credit; or,
- The last day of the first month of the grace period if You receive advance payment of the premium tax credit

Re-enrollment After Termination for Non-Payment

If You are terminated for non-payment of premium and wish to re-enroll with Molina (during Open Enrollment or a Special Enrollment Period) in the following plan year, We may require that You pay any past due premium payments, plus Your first month's premium payment in full, before We will accept Your enrollment with Us.

Termination for Non-Payment Notice:

Upon termination of this Agreement, Molina Healthcare will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended.

If You claim that We ended the Member's right to receive Covered Services because of the Member's health status or requirements for health care services, You may request a review or appeal Our decision. See the section of this Policy titled "Grievances and Appeals".

YOUR RIGHTS AND RESPONSIBILITIES

What are my rights and responsibilities as a Molina Healthcare Member? These rights and responsibilities are posted on the Molina Healthcare web site: MolinaMarketplace.com.

YOUR RIGHTS

You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina.
- Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).
- Be informed about Your health. If You have an illness, You have the right to be informed of all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*

- Complain about Molina or Your care. You can call, fax, e-mail or write to Molina's Customer Support Center.
- Appeal Molina's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina (leave the Molina Policy).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get interpreter services on a 24-hour basis at no cost to help You talk with Your doctor or with Us if You prefer to speak a language other than English.
- Get information about Molina, Your providers, or Your health in the language You prefer.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.
- Free Information on medical necessity criteria due to adverse benefit determinations.
- Get a copy of Molina's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina's contracted hospitals.
- Not to be treated poorly by Molina or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish, or seek revenge.
- File a grievance or complaint if You believe Your linguistic needs were not met by Molina.

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at 1 (888)858-3492.

- Give information to Your doctor, provider, or Molina Healthcare that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed on with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina card when getting medical care. Do not give Your card to others. Let Molina know about any fraud or wrongdoing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals, as You are able.

Be Active In Your Healthcare

Plan Ahead

- Schedule Your appointments at a good time for You
- Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long
- Keep a list of questions You want to ask Your doctor
- Refill Your prescription before You run out of medicine

Make the Most of Doctor Visits

- Ask Your doctor questions
- Ask about possible side effects of any medication prescribed
- Tell Your doctor if You are drinking any teas or taking herbs. Also tell Your doctor about any vitamins or over-the-counter medications You are using

Visiting Your Doctor When You are Sick

- Try to give Your doctor as much information as You can.
- Are You getting worse or are Your symptoms staying about the same?
- Have You taken anything?

If You would like more information, please call Molina's Customer Support Center toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, You may call Our dedicated TTY for the deaf or hard of hearing toll-free at (800) 735-2989. We are here Monday through Friday, between 7:30 a.m. and 6:30 p.m. PT.

MOLINA HEALTHCARE SERVICES

Molina Healthcare is Always Improving Services

Molina Healthcare makes every effort to improve the quality of health care services provided to You. Molina Healthcare's formal process to make this happen is called the "Quality Improvement Process". Molina Healthcare does many studies through the year. If We find areas for improvement, We take steps that will result in higher quality care and service.

If You would like to learn more about what We are doing to improve, please call Molina Healthcare toll- free at 1 (888) 858-3492 for more information.

Your Healthcare Privacy

Your privacy is important to Us. We respect and protect Your privacy. Please read Our Notice of Privacy Practices, at the front of this Policy.

New Technology

Molina Healthcare is always looking for ways to take better care of Our Members. We have a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

Our Medical Directors find new medical procedures, treatment, drugs, and devices when they become available. They present research information to the Utilization Management Committee. These physicians review the technology. Then they suggest whether it can be added as a new treatment for Molina Healthcare Members. For more information on new technology, please call Molina Healthcare's Customer Support Center.

What Do I Have to Pay For?

Please refer to the "Molina Healthcare of Washington, Inc. Schedule of Benefits" at the front of this Policy for Your Cost Sharing responsibilities for Covered Services. Note that You may be liable to pay for the full price of medical services when:

- You ask for and get medical services that are not covered, such as cosmetic surgery.
- You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Molina Healthcare. The exception is in the case of Emergency Services.

If Molina Healthcare fails to pay a Molina contracted provider (also known as a Participating Provider) for giving You Covered Services, You are not responsible for paying the provider for any amounts owed by Us. This is not true for Non-Participating Providers who are not contracted with Molina Healthcare. Benefits for services provided to Your minor Dependent child may be paid to a third party if:

- The third party is named in a court order as the managing or possessory conservator of the child; and
- Molina Healthcare has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to Molina Healthcare, with a claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator. Molina may deduct from its benefit payments any amounts it is owed by the recipient of the payment. Payment to Your or Your provider, or deduction by Molina Healthcare from benefit payments of amounts owed to Molina Healthcare, will be considered in satisfaction of its obligations to You under the plan. You will receive an explanation of benefits so that You will know what has been paid. All benefits paid under this Policy on behalf of a covered Dependent child for which benefits for financial and medical assistance are being provided by the Washington Health and Human Services Commission shall be paid to said department when the parent who purchased the individual has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support. Molina Healthcare must receive at its Washington office, written notice affixed to the claim when the claim is first submitted, and the notice must state that all benefits paid pursuant to this section must be paid directly to the Washington Health and Human Services Commission.

What if I have paid a medical bill or prescription?

(Reimbursement Provisions)

While most claims for payment of Covered Services will be submitted directly by Your Participating Providers, You may incur charges for Covered Services. These can be submitted by You as a claim to Molina Healthcare. For example, You may have received Emergency Services from a Non-Participating Provider. With the exception of any required Cost Sharing amounts (such as a Copayment or Coinsurance), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina Healthcare will pay You back.

You will need to mail or fax Us a copy of the bill from the doctor, hospital, or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on the Welcome page of this Policy. All claims must be properly submitted within 90 days of the date that You receive the services or supplies. Claims not submitted and received by Molina Healthcare within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

After We receive Your claim, We will notify You in writing of the acceptance or rejection of the claim within 15 business days after We receive all the information We need to process the claim. If We need additional time, We will notify You of the reasons We need more time and will accept or reject the claim within 45 days. If Your claim is accepted, We will mail You a check within 5 business days after We have notified You. If You do not agree with Our decision, You may appeal Our decision as explained under the Grievances and Appeals section of this Policy.

How Does Molina Healthcare Pay for My Care?

Molina contracts with providers in many ways. Some Molina Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in Referral denials or under-utilization. For more information

about how providers are paid, please call Molina's Customer Support Center toll-free at 1 (888)858-3492. We are here Monday through Friday, 7:30 a.m. to 6:30 p.m. PT. You may also call Your provider's office or Your provider's medical group for this information.

COORDINATION OF BENEFITS

This Coordination of Benefits ("**COB**") provision applies when a person has health care coverage under more than one Plan**. Plan** is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the "**Primary Plan**". The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "**Secondary Plan**". The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense**.**

Definitions
A "**Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law; Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law.

Each contract for coverage under (1) or (2) is a separate Plan**.** If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan**.**

"**This Plan**" means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Pan, the total benefits paid or provided by all plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when this Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for

the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an allowable expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

"**Allowable expense**," except as outlined below means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. When coordinating benefits, any secondary plans must pay an amount, which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it were the primary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

The following are examples of expenses that are not Allowable Expenses**:**

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense**,** unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by two or more Plans that compute their benefit payments based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense**.**
- If a person is covered by two or more Plans that provide benefits or services based on negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense**.**

"**Closed Panel Plan**" is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan**,** and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"**Custodial Parent**" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans**,** the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan**.**

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverage's that are superimposed over hospital and surgical benefits, and insurance type coverage's that are written in connection with a **closed panel plan** to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan**.**

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policy holder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan**.**

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(b) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan**;** or

(c) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan**.**

(d) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the **custodial parent,** first; the Plan covering the spouse of the **custodial parent,** second;
- The Plan covering the **noncustodial parent,** third; and then
- The Plan covering the spouse of the **noncustodial parent,** last

(e) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan**.** The Plan covering that same person as a retired or laid-off employee is the Secondary Plan**.** The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D (1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan**,** the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D (1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan**.**

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan**.** In addition, This Plan will not pay more than it would have paid had it been the Primary Plan**.**

Effect on the Benefits of the Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the **secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim equal one hundred percent of the total Allowable Expense for that claim. T**otal allowable expense** is the highest **Allowable Expense** of the **Primary Plan** or the **secondary plan.** In addition, the **secondary Plan** must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under This Plan and other Plans. Molina may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Molina any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

If payments that should have been made under This Plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, the issuer is fully discharged from liability under This Plan.

Right To Recovery
The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Coordination Disputes
If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Grievances" section, below. If You are still not satisfied, You may call the Washington State Office of the Insurance Commissioner for instructions on filing a consumer complaint. Call 1 (800) 562-6900 or 1 (360) 725-7080, or visit Washington State Office of the Insurance Commissioner website at www.insurance.wa.gov.

Notice to Covered Persons
If You are covered by more than one health benefit plan, and You do not know which is your primary plan, You or your provider should contact any one of the health plans to verify which plan is primary. The health plan You contact is responsible for working with the other plan to determine which is primary and will let You know within thirty calendar days.

Note: All health plans have timely claim filing requirements. If You or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If You experience delays in the processing of your claim by the primary health plan, You or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if You are covered by more than one plan You should promptly report to your providers and plans any changes in your coverage. Time limits for primary and secondary plans may be no less favorable than as set forth in the law.

Advance Directives
An Advance Directive is a form that tells medical providers what kind of care You want if You cannot speak for Yourself. An Advance Directive is written before You have an Emergency. This is a way to keep other people from making important health decisions for You if You are not well enough to make Your own. "Durable Power of Attorney for Health Care" and "Natural Death Act Declaration" are types of Advance Directives. You have the right to complete an Advance Directive. Your PCP can answer questions about Advance Directives. You may call Molina to get information regarding State law on Advance Directives and changes to Advance Directive laws. Molina updates Advanced Directive information no later than ninety (90) calendar days after receiving notice of changes to State laws. For more information, call Molina's Customer Support Center toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the National Relay Service.

GRIEVANCES AND APPEALS

Definitions Used in Grievances and Appeals
"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's or applicant's eligibility to participate in this plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"External Review of Adverse Benefit Determination" means a request by a Member or the Member's designated representative for an Independent Review Organization to determine whether Molina's Internal Review decisions are correct.

"Final External Review Decision" means a determination by an Independent Review Organization at the conclusion of an External Review of an Adverse Benefit Determination.

"Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by Molina at the completion of the Internal Review or Appeal process, or an Adverse Benefit Determination for which the Internal Review or Appeal process has been exhausted.

"Grievance" means a verbal or written complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for, or non-provision of, medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or dissatisfaction with the service provided by Molina.

"Independent Review Organization" means a certified independent review organization established by the Washington State Insurance Commissioner that is not affiliated with Molina. "Internal Review of Adverse Benefit Determination" means the request by or on behalf of a Member to review and reconsider an Adverse Benefit Determination.

What if I Have a Complaint (Grievance)?

If You have a problem with any Molina services, We want to help. Molina recognizes the fact that Members may not always be satisfied with the care and services provided by Our contracted doctors, hospitals and other providers. We want to know about Your problems and complaints. You may file a Grievance (also called a complaint) in person, in writing, or by telephone. You must file Your Grievance within one hundred eighty (180) days from the day the incident or action occurred which caused You to be unhappy. We will never retaliate against a Member in any way for filing a Grievance.

You or a person designated by You to assist can contact Us by telephone or in writing at:

- Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 7:30 a.m. - 6:30 p.m. PT. Deaf or hard of hearing Members may dial 711 for the Telecommunication Service. If You need assistance to file a Grievance in a language other than English or need an accessible format, Our Customer Support Center can make arrangements for translation or interpreter assistance.

- You may also send Us Your Grievance in writing by mail or by filing online at Our website. Our address is:

  Molina Healthcare
  Grievance and Appeals Unit P.O. Box
  4004
  Bothell, WA 98041 MolinaMarketplace.com

We will send You a letter acknowledging receipt of Your Grievance within 72 hours of Our receipt of the request. Grievances will be resolved within thirty (30) calendar days.

Review of Adverse Benefit Determination

When You receive an Adverse Benefit Determination, You can file a request for an internal review of the Adverse Benefit Determination with Molina. We will process Your written or oral request for an internal review of an Adverse Benefit Determination, also called an Appeal. We will never retaliate against a Member in any way for

filing a Grievance.There are two levels of appeals, an Internal Review and an External Review. When the Internal Review is final, You may request an External Review of the Final Internal Adverse Benefit Determination as explained below.

Internal Review of Adverse Benefit Determination

Requests for Internal Review or Appeal of Adverse Benefit Determinations must be received within 180 days of Your receipt of an Adverse Benefit Determination. Requests for Internal Review or Appeals may be made by calling Molina at 888-858-3492 between 7:30 a.m. to 6:30 p.m. PT Monday through Friday, or in writing and sent to the following mailing address or electronic mail address:

Molina Healthcare Grievances and
Appeals Unit P.O. Box 4004
Bothell, WA 98041 MolinaMarketplace.com

We will send You a letter acknowledging receipt of Your request for Internal Review or Appeal within 72 hours of Our receipt of the request. Molina's Internal Review or Appeal procedures will be completed within fourteen (14) calendar days for Adverse Benefit Determinations and twenty (20) working days for appeals involving Experimental and Investigational procedures. We may extend the time it takes to make a decision by up to 16 additional days if We notify You of the extension and the reason for the extension. Any further extensions by Us are subject to Your informed written consent to an extension. An extension will not extend the time for a determination beyond twenty (20) calendar days without Your written consent.

You may submit information, comments, records, and other items to assist in the review. You may review and copy Our records and information relevant to the claim free of charge. We will consider all information submitted prior to making Our determination. Our review will be performed by persons who were not involved in the original decision and if the Adverse Benefit Determination involved medical judgement, the reviewer will be someone who is or consults with, a health care professional who has appropriate training and experience in the field of medicine encompassing Your condition or disease and make a determination that is within the clinical standard of care for Your disease or condition.

If You are receiving services that are the subject of an Internal Review or Appeal, those services will be continued until the Internal Review or Appeal is resolved if You request the continuation. However, if Molina prevails on final determination of the Internal Review or Appeal, You may be responsible for the cost of the coverage received during the review period.

After the Internal Review or Appeal is complete, We will send You a written decision on Your appeal determination, no more than two (2) business days after the review has been completed, and will provide information about what We considered, including the clinical basis for Our determination and how You can obtain the clinical review criteria used to help make the decision. If applicable, We will also provide You with information for obtaining an External Review or Appeal of a Final Internal Adverse Benefit Determination. Our decision, and any documents related to the decision, will be provided to you at the address We have on record for You, or with Your written consent such records may be sent electronically.

Expedited Review of Adverse Benefit Determination

You may request an expedited Internal Review or Appeal of an Adverse Benefit Determination if one of the following conditions applies:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination; or
- If Your provider believes that a delay in treatment based on the standard review time may seriously jeopardize Your life, overall health, or ability to regain maximum function, or would subject You to severe

and intolerable pain; or
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and You have not been discharged from the emergency room or transport service.

Requests for expedited Internal Review or Appeal may be made in writing or by telephone. You, a person designated by You to assist, or Your provider may contact Us by telephone or in writing at:

If Your Provider determines that a delay could jeopardize Your health or ability to regain maximum function, Molina will presume the need for an expedited review and treat the review as such, including the need for an expedited determination of an external review.

- Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 7:30 a.m. - 6:30 p.m. PT. Deaf or hard of hearing Members may dial 711 for the Telecommunication Service.

- Molina Healthcare Grievances and Appeals Unit
  P.O. Box 4004
  Bothell, WA 98041
  MolinaMarketplace.com

You may submit information, comments, records, and other items to assist in the review. You may review and copy Our records and information relevant to the claim free of charge. We will consider all information submitted prior to making Our determination. This review will be conducted by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers will be individuals who were not involved in making the initial Adverse Benefit Determination.

If Molina requires additional information to determine whether the service or treatment decision being reviewed is covered under this Agreement, or eligible for benefits, Molina will request such information as soon as possible after receiving the request for expedited review.
We will notify You of Our decision to an expedited Internal Review no later than 72 hours after Your initial contact with Us. If Our decision was delivered orally, Our decision will be issued in writing not later than 72 hours after the date of the decision.

You may also request a concurrent expedited review of an Adverse Benefit Determination, which means that the Internal Review or Appeal and the External Review or Appeal are handled at the same time. Concurrent expedited reviews are available if one of the following conditions applies:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination.
- If Your provider believes that a delay in treatment based on the standard review time may seriously jeopardize Your life, overall health, or ability to regain maximum function, or would subject You to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and You have not been discharged from the emergency room or transport service.

Requests for concurrent expedited review may be made in writing or by telephone. You, a person designated by You to assist, or Your provider may contact Us by telephone or in writing at:

- Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 7:30 a.m. - 6:30 p.m. PT.
- Deaf or hard of hearing Members may dial 711 for the Telecommunication Service.
- Molina
  Grievances and Appeals Unit
  P.O. Box 4004

Bothell, WA 98041

MolinaMarketplace.com

Molina will issue a formal response no later than 72 hours after Your initial contact with Us. Please see below for more information on External Review or Appeals.

External Review of Adverse Benefit Determination

Within 180 days after You have received Our Final Internal Adverse Benefit Determination, or if We have not responded to Your request for an Internal Review or Appeal within the time periods noted above, You may request an External Review or Appeal from an Independent Review Organization ("IRO"). Requests for External Review or Appeals must be in writing and sent to the following mailing address or electronic mail address:

Molina Healthcare Grievances and
Appeals Unit P.O. Box 4004
Bothell, WA 98041
MolinaMarketplace.com

Upon receipt of a valid request for an External Review or Appeal, Molina will arrange for the review from an Independent Review Organization (IRO) at no cost to You, and will provide You with the IRO contact information within 24 hours of selecting the IRO. The IRO is unbiased and not controlled by Us. We will provide the IRO with the appeal documentation, but You may also provide them with information.

The IRO process is optional and You pay no application or processing fees of any kind. You have the right to give information in support of Your request and have 5 business days from the request for an External Review or Appeal to submit any supporting written information to the IRO. If You are receiving services that are the subject of the appeal, those services will be continued until the matter is resolved by the IRO if You request the continuation. If Our Adverse Benefit Determination is upheld by the IRO, You may be responsible for paying for any services that have been continued during the External Review or Appeal.

The dispute will be submitted to the IRO's medical reviewers who will make an independent determination of whether or not the care is Medically Necessary or appropriate and the application of this Policy's coverage provisions to Your health care services. All documents submitted to the IRO will also be made available to You. This includes all relevant clinical review criteria, all relevant evidence, providers recommendations and copy of this Agreement. You will get a copy of the IRO's Final External Review Decision. If the IRO determines the service is Medically Necessary or appropriate for coverage under the Policy, Molina will provide the health care service.

If Your case involves Experimental or Investigational treatment, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account.

For non-urgent cases, the IRO must provide its determination within the earlier of fifteen (15) days after the IRO receives the necessary information or twenty (20) days of receipt of Your request.

You may request an expedited External Review or Appeal if one of the following conditions apply:

- You receive a Final Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care service for which You received emergency services and have not been discharged from the facility.
- You receive a Final Adverse Benefit Determination involving a medical condition for which the standard external review time would seriously jeopardize Your life or health or jeopardize Your ability to regain maximum function.

- Your request for a concurrent expedited review is granted.

If the External Review or Appeal is expedited, the IRO must notify You within 72 hours of its Final External Review Decision. If the notice is not in writing, the IRO must provide You with written confirmation of its Final External Review Decision within 48 hours after the date of the decision.

For more information regarding the External Review or Appeal process, or to request an appeal, please call Molina toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the Telecommunication Service.

Washington State Office of the Insurance Commissioner

If You have any questions or grievances regarding Our handling of Your grievance or appeal, You may contact the Washington State Office of the Insurance Commissioner. A Washington State Office of the Insurance Commissioner representative will review Your issues, and if the representative can't help You, he or she will point You in the right direction for further assistance.

The Washington State Office of the Insurance Commissioner's Consumer Protection Division is currently designated by the U.S. Department of Health and Human Services as the official ombudsman in the State of Washington for consumers who have questions or complaints about health care appeals

Washington State Office of the Insurance Commissioner
Call 1 (800) 562-6900 or
Call 1 (360) 725- 7080
TDD 1 (360) 586- 241
Fax to 1 (360) 586-2018
Email CAP@oic.wa.gov

MISCELLANEOUS PROVISIONS

Acts Beyond Molina's Control
If circumstances beyond the reasonable control of Molina, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Molina and the Participating Provider shall provide or attempt to provide Covered Services in so far as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina nor any Participating Provider shall have any liability or obligation for delay or failure to provide Covered Services if such delay or failure is the result of any of the circumstances described above.

Waiver
Molina's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement, or impair Molina's right to require Your performance of any provision of this Agreement.

Non-Discrimination
Molina does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity. If You think You have not been treated fairly please call the Customer Support Center toll-free at 1(888) 858-3492.

Organ or Tissue Donation
You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. You may choose to be an organ tissue donor by registering with the Washington Department of Licensing when You apply for or renew Your Driver's License or by going online at www.donatelifetoday.org to add Your name to the registry.

Agreement Binding on Members
By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder without Molina's prior written consent (which consent may be refused in Molina's discretion).

Governing Law
Except as preempted by federal law, this Agreement will be governed in accordance with Washington law and any provision that is required to be in this Agreement by state or federal law shall bind Molina Healthcare and Members whether or not set forth in this Agreement.

Invalidity
If any provision of this Agreement is held not in conformity with applicable laws in a judicial proceeding or binding arbitration, such provision shall not be considered to be invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws, and the remainder of this Agreement shall remain operative and in full force and effect.

Notices
Any notices required by Molina Healthcare under this Agreement will be sent to the most recent address We have for the Subscriber. The Subscriber is responsible for notifying Us of any change in address.

Wellness Programs

Your Policy includes access to a health activity program. The goal of the program is to encourage You to complete a health activity that supports Your overall health. The program is voluntary and available at no additional cost to You. The health activity we encourage you to complete, is described below. For more information, please contact Member Services phone number on your ID Card.

Annual Health Activity
We encourage You to complete the annual health activity below during the calendar year. Upon completion, Molina may work with You to support Your overall wellness.

Annual Wellness Exam

- Provides You with the opportunity to obtain either an annual comprehensive physical exam through your Primary Care Provider, or an In-home health assessment exam facilitated through Molina.

Program Benefit
For participating and completing the annual health activity, you will receive a program benefit gift card. Maximum program benefit is one gift card, per calendar year. You will receive the program benefit gift card by mail at the mailing address that is on file with Molina:

Annual Health Activity	Annual Program Benefit
Complete an Annual Wellness Exam	You will be paid at no less than $50 for your participation.

HEALTH EDUCATION PROGRAMS

The tools and services described here are educational support for Our Members. We may change them at any time as necessary to meet the needs of Our Members.

HEALTH EDUCATION

Molina Healthcare offers programs to help You and Your family manage a diagnosed health condition. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management

You can get information or join any of the programs above by calling the Molina Health Management Department at 1 (866) 891-2320 8:30 a.m. and 5:30 p.m. (PT), Monday through Friday. You may also call us if you wish to stop receiving program materials.

Newsletters

Newsletters are posted on the www.MolinaHealthcare.com website at least 2 times a year. The articles are about topics asked by members like you. The tips can help you and your family stay healthy.

Health Education Materials

Our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, ask your doctor or visit our website at:MolinaMarketplace.com/MPHealthEducation.

Department/Program	Type of help needed	Number to call/ Contact information
Molina Healthcare Customer Support Center Department	If You have a problem with any of Molina Healthcare's services, We want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 7:30 am to 6:30 pm. PT. When in doubt, call Us first.	Customer Support Center Toll Free: 1 (888)858-3492 TTY line for the deaf or hard of hearing: 1 (800) 735-2989 or dial 711 for the Telecommunications Service
Health Education	To request information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes. To request any information on programs for conditions such as asthma, diabetes, high blood pressure, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD)	1 (866) 891-2320 between 8:30 a.m. and 5:30 p.m. (PT) Monday through Friday
Nurse Advice Line 24-Hour, 7 days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750 for Spanish: 1 (866)648-3537
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that We have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE TTY for deaf or hard of hearing: 1 (877) 486-2048 **www.Medicare.gov**
Washington State Office of the Insurance Commissioner	The Washington State Office of the Insurance Commissioner is responsible for regulating health care services plans.	(800) 562-6900 or 1 (360) 725-7080 **TDD 1 (360) 586-0241** Fax to 1 (360) 586-2018 www.insurance.wa.gov